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SURGICAL TUBERCULOSIS.¹

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SURGICAL tuberculosis, I take it, includes such forms of tuberculous disease as may be amenable to surgical treatment. Each year, as these pathologic conditions are better appreciated, the possibilities of surgical help increase.

Tuberculosis appears in various guises: Lupus is skin-tuberculosis; the connective tissue has its tuberculous abscesses; in the nose, mouth, and larynx it is seen as a primary affection, to say nothing of the lungs, where it is most frequently encountered. Tracing its course further along the mucous membranes, we find it invading the alimentary canal, appearing in the genito-urinary tract of both male and female, and awakening peritoneal infection. Again it is seen in the glandular structures, most frequently in the neck. The long and short bones, the joints, the spine are common sites of its occurrence. The special organs are not free. In fact, it would be difficult to suggest a structure in which it has not appeared as a primary disturbance. Diseases formerly called by other names are now recognized as being tuberculous, under which head we might mention scrofula, caries, tumor albus, and hip-joint disease. Even the deeply placed organs, as the kidneys, the Fallopian tubes, and ovaries, do not escape the incursions of the tubercle bacillus. This enumeration, in itself very incomplete, suggests how inexhaustible must be the subject of the surgical treatment of tuberculosis. I can, therefore, present the disease in but a few phases, and, rather than attempt to consider its many different surgical forms, shall restrict myself to the discussion of the more frequently encountered varieties.

A brief preliminary word before we enter upon our specific task. No one to-day holds to the constitutional origin of tuberculosis. We must regard it as a local infectious disease, awakened by the introduction of the specific germ into tissues whose resistance has been lowered. That tubercle-bacilli can enter through unbroken mucous membranes is

not to be questioned. Cornet presented the result of his experiments to the French Surgical Congress in 1889, in which he showed that tuberculous glandular swellings could be produced in guinea-pigs as the result of rubbing tubercle-bacilli into a mucous membrane without lacerating it. At the request of Volkmann, Schuchardt studied so-called scrofulous invasion of the skin and mucosa presenting nothing unusual microscopically. In an instance of eczema of the forearm the bacilli were found between the scales of the epidermis. These points suggest the manner in which the local forms of tuberculosis originate.

However introduced, whether finding its way to glands through the mucous membrane, by way of the lymphatics, or discharged into the blood-current and locating itself as an embolic plug at a remote part of the body, the infection establishes itself first locally, heaping up its characteristic nodules, involving the surrounding structures, building up large fungous growths or forming caseous masses, ultimately producing local abscesses, or leading to constitutional disturbances. Again, it may awaken in the surrounding tissues reactionary inflammation, and secure thus a spontaneous arrest of the tuberculous process, while the bacilli and their spores, possessing remarkable vitality, may lapse as it were for a time in a state of "innocuous desuetude." Baumgarten discovered in autopsies made upon persons dying of other than tuberculous diseases, that one out of every four had latent tuberculous foci in the lungs. And so elsewhere in the body, the tuberculous areas may become quiescent, and particularly so under conditions favorable to such a result. Thus a tuberculous affection of the lungs or other structures need not necessarily lead in the first instance to death of the individual, nor in the latter to local necrosis.

GLANDULAR TUBERCULOSIS. Not all chronic enlarged glands of the neck are tuberculous. Much the larger percentage, however, of those that show no disposition to diminish, but remain latent or increase in size, and especially if they exhibit a tendency to suppurate, are tuberculous. The general physician has been accustomed to treat this latter condition with poultices. When the glands have broken down and pus has reached the surface he makes an incision and gives vent to the purulent collection. Nature has to do the rest. No more unsurgical course could be pursued.

¹ Read before the Onondaga County Medical Society, December 18, 1894, being part of the discussion on "Tuberculosis."

The tuberculous character of the glands being recognized, two lines of treatment are open: First, to secure the removal of the glands before the surrounding structures are involved; or, second, to wait until the structures are broken down, when we have to deal not only with glandular but also with periglandular inflammatory disease.

At the meeting of the British Medical Association, in 1893, it was the consensus of opinion of the section discussing this subject, that medical treatment in itself is of no avail beyond the benefits that come from improving the general tone. The early removal of the glands is advised, first, for esthetic purposes, as late removal of these structures leads to unsightly scars. But their removal for pathologic reasons is more to the point. If the glands can be excised without infecting the surrounding tissues, the wound can be closed, and union, by first intention results. If a single gland is found caseous, the other glandular enlargements are probably in a similar condition, and their removal is desirable. Care should be taken to excise the glands entirely, as any tuberculous focus left behind will generate suppurative inflammation. The incision should be free enough to give access to all diseased masses. Some surgeons make a series of small incisions over the individual glands in order to avoid any apparent disfigurement. Others seek to establish a line of incision at a point where the scar will be least visible.

It is particularly to suppurative cases that I desire to call attention. To incise simply the abscess is not to lay bare the tuberculous focus. The diseased gland may simply be connected with it through a sinus. Again, one leaves behind the broken-down tuberculous mass a collection of infectious material. These cases demand free incision, thorough curettage with a Volkmann spoon, disinfection with a sublimate-solution, and packing with iodoform-gauze. The danger of disseminating tuberculous disease by these steps is very small indeed. The operation for the excision of tuberculous glands, whether caseous or suppurative is a perfectly innocent procedure.

There is another phase in which these conditions should be regarded, that is, the danger, if allowed to remain, of remote infection by them. It is a common observation to see individuals with tuberculous glands develop at a later period pulmonary or other forms of tuberculosis. A child that was seen by me two years ago, with tuberculous lymphatics of the neck, and whose mother would not consent to their removal, this summer suffered from an extensive tuberculous iliac abscess.

BONE-TUBERCULOSIS AND JOINT-TUBERCULOSIS. With the ever-increasing fund of knowledge, new principles in tuberculous disease of the bones and joints are being constantly established. It is there-

fore proper to refer again to this subject. Tuberculosis has a predilection for bones or portions of bones largely made up of cancellous tissue. So we have tuberculosis of the vertebrae or "Pott's disease," manifesting itself as a most frequent form of bone-disease. Of the joints, because of the histologic structure of their bony constituents, the knee and the hip are most frequently affected. In four-fifths of the cases other tuberculous manifestations co-exist.

To diagnosticate the condition before the destructive stage of tuberculosis is reached is most essential. There is every reason to believe that we can arrest the lesions in their early stage. Allowed to suppurate, impaired function and deformity are the best result that can be attained. Chronic joint-inflammation requires surgical rather than medical treatment. Fixed points of tenderness, nocturnal pain, muscular rigidity, and particularly muscular atrophy, impaired function, changed position and form, are to be carefully noted.

Not only does timely treatment secure more serviceable extremities, but with their neglect tuberculous diseases of bones and joints may awaken remote infection. A case that I saw with Dr. Murray and reported by him, in which pulmonary tuberculosis followed upon tuberculous disease of the wrist-joint, exemplifies this. The close relationship between pulmonary tuberculosis and joint-tuberculosis is likewise evident in the subsidence of serious tuberculous lesions in the lungs upon removing a tuberculous joint. As an example of this kind I have to refer to a case seen by me in April, 1886. A tuberculous hip received conservative treatment, and the disease became quiescent. Subsequent traumatism reawakened the trouble; with the recurrence came hectic fever, night-sweats, emaciation, pulmonary invasion, and pulmonary hemorrhage. On the 27th of April, 1887, I resected the hip. Despite the boy's reduced condition, he made a recovery, not only as to the condition of his extremity, but the pulmonary disease became retrogressive, disappeared, and he has remained well since, now seven years.

When the infectious character of bone-tuberculosis became recognized surgeons at once took the ground that the only course to be pursued was the removal of the tuberculous site. This led to an enormous number of minor operations and resections upon the bones and joints in search of the diseased area.

In the early period of tuberculous invasion of joints of the lower extremities nothing has accomplished so much as rest in the recumbent posture, with weight-extension. The period of time to be occupied by this treatment is much longer than is usually deemed necessary. Failure to observe this

leads to failure of the treatment. Howard Marsh, one of the most earnest advocates of this line of procedure, states that the average period required for the cure of these cases is about eighteen months. He makes it a rule never to allow a patient to be up until at least three months have passed after the cessation of pain. He has found that the maintenance of the horizontal position for one or two years, in good air, with weight-extension, is not prejudicial to the patient's health. Only once I have found it necessary to continue the confinement in bed over one year. This boy improved in health steadily during the entire period.

When the disease has led to marked organic disturbance, further steps become necessary. During the so-called antiseptic period, and until within a very recent period, operative intervention has been the accepted method for treatment. Under it, Schede and others, in the advanced cases, however, had a mortality of 66 per cent.

Tuberculin, when introduced, was claimed to be a panacea for all tuberculous affections. It was tried in cases of surgical tuberculosis. Much was expected, and its use became general, but in spite of the glowing accounts of its excellent qualities the mortality steadily increased until 75 per cent. of those treated with it who were suffering from tuberculous joint-disease died. On the other hand, a line of procedure has now been instituted which has had most marvellous effects. It is the introduction into the joint of a sterilized solution of iodoform in glycerin or oil; 10 or 20 per cent. solutions are injected. Of the former, ten c.c., that is, two-and-three-quarters drams, and of the latter one-half that quantity is used. At the end of eight days a second injection is made. In the meantime cold applications are applied to the joint. Depending upon the severity of the case, the number of injections varies. Absolute contact with the diseased surface is necessary. Some discontinue its use, if no benefit follows four or five injections. This treatment has been pursued quite extensively in this country, and I have had not a little experience with it. The mortality has fallen to 20 per cent. under the iodoform-emulsion, and the number of resections has been reduced one-half. Upon this point the German surgeons are substantially agreed. Bergmann, for example, prior to 1891, resected from thirty to forty hip-joints annually. During that year, with the same number of cases presenting themselves, he operated upon eleven. Of thirty-six tuberculous knee-joints, thirty-one were cured by injection, and only five had to be operated on. The fixed policy of the German surgeons to-day is not to resort to operative intervention until conservative measures have been given a fair trial.

In France Lannelongue has been using a 10 per

cent. solution of zinc chlorid. Instead of injecting it into the joint, he applies it just outside of the diseased area, for the purpose of lighting up there, as Nature herself often does, a reactionary inflammation. He introduces a hypodermic needle into different points about the joint, as close to the attachment of the capsule to the bone as possible, until he has gone completely around it. Before the application the joint is placed in its normal position. The operation is done under antiseptic precautions, with the patient anesthetized. It is not repeated in less than three weeks. Other solutions have been used. One deserving mention is the suggestion of Landerer. In 1892 he began the use of a solution of cinnamic acid, five parts to ten of olive-oil, the yolk of one egg, and 100 parts of a normal saline solution, rendered alkaline before its injection. Of all, however, the iodoform-emulsion alone has established itself securely with the profession.

As to the ultimate course of joint-tuberculosis, one of the most interesting studies presented recently is the report of Bruns to the German Surgical Congress, last April. With Dr. Wagner he carefully reviewed the records of the surgical clinic at Tübingen for the past forty years. Six-hundred cases of hip-joint disease had been treated during this period. Of these, upward of two-hundred are yet alive, and each was personally examined. That no doubtful case might be considered as tuberculous, all that ran a course of less than a year-and-a-half, or such as recovered without impaired function of the joint, were excluded. In this way the number was reduced to 390; 321 had been treated conservatively, and 69 by resection.

Tuberculous coxitis was found to be a disease appearing substantially during the first two decennial periods of life, 85 per cent. of the cases having occurred before the twentieth year. In one-third there had been no suppuration; in the other two-thirds abscesses and sinuses existed; 55 per cent. recovered under conservative treatment, the average period being four years; 40 per cent. died of tuberculous diseases of the internal organs. The appearance of suppuration increased the mortality 23½ per cent. The earlier in life the disease appeared the more favorable was found to be its course. Thus, 65 per cent. of those existing during the first decennium recovered; in the second 56 per cent.; in the third and fourth 28 per cent., while no recoveries occurred in cases appearing after the fiftieth year. A number recovering from the tuberculous disease of the hip-joint succumbed later to other forms of tuberculosis. Those who as children had been severely sick, had been puny and wretched, after a period of from ten to thirty years were found to be perfectly healthy, vigorous, and, though deformed, did not deserve the name of "cripples." Joint-motion

was restricted in all; in one-third it was partial; in two-thirds there was almost complete ankylosis. Faulty position existed, usually flexion with abduction, compensated to a certain extent by the pelvis. There was shortening, varying from one to twelve centimeters. Only a German surgeon would so thoroughly follow up a list of cases covering a period of nearly half a century and determine their ultimate outcome.

PERITONEAL TUBERCULOSIS. Permit me to glance hastily at another form of tuberculosis which, during recent years, has become amenable to surgical treatment. I refer to the peritoneal variety. Like forms of tuberculosis attacking other serous cavities, as the pleural or synovial, it is usually dependent upon a neighboring tuberculous focus. It may be associated with the genital tract in woman. Recently it has been discovered that conditions which had presumably been considered purely inflammatory, involving the ovaries and Fallopian tubes, are frequently tuberculous. Tuberculous peritonitis is not by any means restricted to adult life. Hartman, in 1892, collected, almost entirely from French literature, forty-eight cases in which children had been operated upon for tuberculous peritonitis, and only two of whom had died. The disease appears under different forms. First as ascites, in which the fluid is either clear or turbid or occasionally purulent. Here the serous membrane is found studded with miliary tubercles. A second variety presents thick adhesions, walling off this fluid into well-defined cavities and conveying the impression to the clinician of the existence of a localized cystic tumor. In the third group the tissues are matted together, the intestines glued to one another, even to the degree of intestinal obstruction, ulcerated or perforated. The lymphatics are enlarged and caseous at times, but no fluid is present. Pressure may lead to extensive edema of the lower extremities. Such was the condition in a case that I have reported, in which the primary focus was located in a mid-lumbar vertebra, the retro-peritoneal glands being greatly enlarged and in which there co-existed tuberculous disease of the kidneys and bladder.

Medicinal treatment has proved of but little benefit, although cases have recovered without operation, in which the diagnosis of tuberculous peritonitis has been made. One such case I have seen. Henoch, however, laid down the rule that all cases of chronic peritonitis that recover spontaneously are not tuberculous. As opposed to the medicinal treatment in these cases, the benefits that have almost universally attended celiotomy have been one of the surgical surprises of recent times. How opening the abdominal cavity benefits this condition no one knows. The explanations offered are altogether too numerous to review. The profession is agreed only so far

that celiotomy does cure. It seems to be more beneficial in the ascitic cases, whether the fluid be in the free peritoneal cavity or restricted by adhesions. It is of much less benefit in the third group, in which there is no fluid, but in which marked plastic disturbance exists.

The number of cases operated upon is very large. Unless there be general tuberculosis, the operation is not contraindicated. Talleyrand has said statistics are but lying figures, yet probably the result is fairly stated by Koenig, who, in 1891, had collected one-hundred-and-thirty cases, with a death-rate of 3 per cent., and with a record of twenty-three improved and eighty-four cured. Almost the earliest recorded case is that of Spencer Wells, operated in 1862. The patient, an unmarried lady, presented an abdomen distended to the size of a full-term pregnancy. A cyst was suspected, but instead there was ascites, and the peritoneum was found studded with myriads of tubercles. The woman recovered, and now after more than thirty years remains free from any subsequent disturbance. A young lady upon whom I operated upward of four years ago remains perfectly well.

GENITO-URINARY TUBERCULOSIS. The genito-urinary tract is found to be frequently the seat of primary tuberculosis. From the meatus to the supra-renal capsule no tissue seems to have escaped primary invasion, while in both sexes the genital tract, at various points, has likewise been the initial site of tuberculous disease. Occurring in the urinary organs it is not always possible to establish a diagnosis, as the tubercle-bacillus is not readily found until the disease has advanced perhaps beyond operative relief. Schuchardt has remarked that tuberculous invasion is more frequently of venereal than of hematogenous origin. A mixed infection may exist when apparently only the characteristic sore of primary syphilis is present. Later the glands show that there has been tuberculous invasion. With gonorrhea, tuberculous epididymitis has occurred, although the first appearance differs in no regard from ordinary gonorrhea, except that tubercle-bacilli are found associated with the gonococci. The introduction of tubercle-bacilli without laceration of the mucous membrane occurs, he claims, after the manner mentioned earlier in this paper. But, however, entering, the tubercle-bacilli have found in the genito-urinary organs sites most favorable for their development, and when awakened we have to deal with one of the most unfavorable forms of tuberculosis from a prognostic standpoint. When the primary manifestation is in the epididymis, or testicle, the only safeguard against further invasion is the removal of the tuberculous focus, which at least is possible in this situation.

An interesting case of this kind has been under

my observation for fully ten years, in which the patient, a clergyman, has suffered from tuberculous disease of the epididymis, prostate, and bladder, and later of the sternum. Under conservative treatment he has been able to continue with his pastoral duties, and is indeed quite vigorous. On November 10, 1893, a patient who had presumably been suffering from an ordinary attack of gonorrhea since the preceding spring presented himself to me with a fistulous opening on the right side of the perineum. Flabby granulations existed at the opening, and the surrounding structures were infiltrated. His attending physician had diagnosticated an ischio-rectal abscess. However the injection of hydrogen dioxid into the sinus found its way out of the urethra at the meatus. A close observation of the case led to the conclusion that it was associated with deep-seated urethral tuberculosis. The wall of what had been a cold abscess and its fistula were curetted clear up to its prostatic commencement, and perineal section was performed. The bladder was drained by a catheter carried through the perineal orifice for a month, during which period granulations sprang up, and the urethra was walled off from the old abscess-cavity. Slow convalescence followed, and in the course of six months the parts became thoroughly healed and remain so.

When the tuberculous site is higher up, that is to say, either in the bladder or kidney, the outlook is particularly unpromising. Removal of a tuberculous kidney, justifiable only when the disease is limited to one, is, as has been my experience, followed often by death from pulmonary tuberculosis. Nor is it always possible to determine where the primary focus is located. An example of this was found in a patient upon whom I operated at St. Joseph's Hospital, February 18, 1893, for an enormous iliac abscess of the left side. Both anterior and posterior openings were made and several quarts of pus evacuated. A coincident cystitis led me to believe that we were dealing with tuberculous disease of the urinary tract. The opinion was expressed that the kidney was probably the primary source of the infection. Our bacteriologist failed to discover tubercle-bacilli. Later on it became necessary to open through the acetabulum to secure better drainage. The patient improved sufficiently to return to his home. After a brief respite the disease again rapidly advanced, and the man died. Dr. Breese, who had attended him during his sickness, was permitted to make an autopsy, and informed me that a fistulous tract crossed the body to the right kidney, which was disorganized by disease, while the left, upon the side corresponding to the abscess, was not involved.

This many-sided disease could occupy one indefinitely in merely superficially examining its various

phases. I had expected to consider other forms in which the surgeon frequently encounters tuberculosis, but I have already occupied too much time.

ANTE-PARTUM OPHTHALMIA NEONATORUM. (INTRA-UTERINE OPHTHALMIA)

BY HARRY FRIEDENWALD, M.D.,
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A NUMBER of States have passed laws with a view to decrease the still large proportion of blindness due to ophthalmia neonatorum. Among these States we are happy to name Maryland, whose last Legislature showed its wisdom in enacting a law making it a punishable offence for a midwife or other person having charge of an infant to treat any ophthalmia, and necessitating the calling of a physician. These laws are the outcome of the experience that ophthalmia neonatorum is a very tractable disease when properly cared for. Some physicians have gone so far as to claim that this disease is always curable when treated early. But even our best ophthalmic surgeons occasionally lose a case through corneal involvement, and recent discussion proves that it is an unavoidable accident in an *exceedingly small number of cases*.¹

It is important to examine into the various conditions under which cases are lost and to determine how they lead to blindness in spite of prophylactic measures and of early and proper treatment.

Ophthalmia neonatorum develops, as a rule, on the second or third day after birth. Infection usually occurs during the passage of the child's head through the vagina. The intervening time is known as the period of incubation, during which the eye presents no signs whatever of disease. This period lasts at least twenty-four hours. It so rarely happens that the disease makes its appearance earlier than the second or third day that none of our textbooks makes mention of it. And yet there are a number of cases on record of children born with the well-marked signs of this disease. In these cases the period of incubation had passed, and the stage of inflammation was more or less advanced at birth.

The entire number of such cases that I have been able to collect in medical literature is eighteen. They are as follows:

1. Hirschberg² saw a child, twelve hours old, with well-marked ophthalmia neonatorum; there was swelling of the lids, pus in the conjunctival folds, and a diffuse opacity of both corneaæ. Labor had been easy, but the membranes had ruptured three days before. The final result was a small

¹ Randall: Trans. Amer. Ophth. Soc., 1893. Woods: Annals of Ophth. and Otol., 1894.

² Beitr. zur prakt. Augenheilk., Berlin, 1876.

leukoma of the right cornea and phthisis bulbi of the left eye.

2. Rivaud-Landraud¹ has published a case of complete destruction of the cornea from ophthalmia two days after birth.

3. Magnus² found ophthalmia fully developed five hours after birth. The membranes had ruptured almost three days before. Both corneæ had gray infiltrations at birth. Large opacities remained.

4. Paryschev's³ case, in which the membranes ruptured three days before birth. There was typical ophthalmia when the child was born, and extensive opacities of the corneæ. The purulent secretion contained many gonococci. He advises prophylactic vaginal irrigation after the membranes have ruptured, using a solution of mercuric chlorid (1:2000 or 1:3000) for this purpose.

5. Krukenberg⁴ demonstrated a child which presented swelling of the eyelids and conjunctiva, and cloudiness of the right cornea, when born. Gonococci were found in the conjunctival secretion (not purulent) and also in the vagina of the mother. The rupture of the membranes had taken place two days before birth.

6. He mentions that Keller had a similar case, in which the rupture of the membranes had occurred seventeen hours before birth.

7. Feis⁵ reports a case of marked ophthalmia neonatorum (great swelling of both upper lids and profuse yellow, watery secretion) without involvement of the corneæ. There were gonococci in numbers. The mother had no vaginal discharge, but a greenish-yellow cervical secretion adhered to the examining finger (latent gonorrhea). The vagina was frequently irrigated with a 1½ per cent. solution of carbolic acid. The author believes that the infectious cervical secretion was carried to the eyes of the infant by the examining finger. In Haussmann's *Bindehaut-infektion bei Neugeborenen*, 1882, mention is made of

8. Galezowski's case of ophthalmia neonatorum noticed at birth, but the details are not given.

9. Feis cites a case that occurred at the Vienna "Findelhaus" in 1863. The child was born with both corneæ destroyed and the irides prolapsed, in consequence of intra-uterine ophthalmia.

10. Haussmann⁶ reports a case in which redness and swelling of the conjunctiva were noticed at birth, the affection disappearing in several days; the rupture of the membranes had not occurred prematurely. The author assumes that the pathogenic substances had made their way through the unbroken membranes.

11. Winckel⁷ has reported a case of ophthalmia in a child when born, but we have been unable to get the details.

Bellouard⁸ reports the following cases as occurring in the practice of Dianoux, Guilbaud, and himself.

12. Dianoux had a patient suffering with vaginal blennorrhea for several months. Fearing ophthalmia neonatorum, he used injections of sublimate (1:100) and of silver nitrate (1:100). Labor was rapid. On account of the numerous injections it was impossible to tell when the membranes had ruptured. One hour after birth a few drops of a 2 per cent. solution of silver nitrate were instilled. In ten hours the lids were tumeied, but the affection was rapidly checked by treatment.

13. Dianoux was called to a case of ophthalmia neonatorum which had made its appearance on the day that the child was born. The inflammation greatly increased, and one cornea was much damaged. The mother had had a vaginitis, but it had been treated with care. The membranes had broken two days before birth.

14. Guilbaud saw a case in which the membranes had ruptured sixty hours before birth. The child's eyelids were enormously swollen when it was born, and pus and blood were discharged when the lids were opened. They were treated with boric acid, and later with silver nitrate, and were completely cured. The mother had had a vaginitis.

15. In one of Bellouard's cases labor began at 3 A.M., at which time the bag of waters was found intact. At 11 A.M. the child was born. Repeated examinations were made by students. At the moment of birth the lids were found agglutinated, red, and swollen. A 2 per cent. solution of silver nitrate was instilled. At 4 P.M., thick greenish pus was discharged. Recovery was rapid. The mother had leukorrhea for four months before labor.

16. In another case of Bellouard's rupture took place nineteen hours before birth, at the beginning of labor. At birth the lids were red and swollen, and three hours later there was an abundant discharge of a thick fluid. The eyes were entirely closed. The mother had a severe vaginitis, and enormous vegetations. In these cases frequent examinations had been made during labor.

17. In Looten's case⁹ the child was admitted to the hospital one day after it was born, at which time there was chemosis of the eyelids that had probably existed for at least twenty-four hours. The cornea of one eye was involved.

18. Fers¹⁰ reports the case of a child, born fifty-four hours after rupture of the membranes, presenting well-marked blennorrhea of both eyes. Gonococci were discovered in the secretion.

19. The following case came under my observation at the "Maternité" of Baltimore. The mother had chancroids and venereal warts. The child was born July 2, 1890, the mother having been in labor for two days. The membranes broke at 6:15 A.M., and the child was delivered at 9 A.M. of the same day. Silver nitrate (2 per cent.) was in-

¹ Cited by Hirschberg.

² Zehender's Monatsbl. für Augenheilk., 1887, p. 389.

³ Summarized in Hirschberg's Centralbl., 1893, p. 64.

⁴ Verhandl. d. Gesellsch. f. Geburtsh. und Gynaekol., June, 1891.

⁵ Centralbl. f. Gynaekol., 1892, No. 45.

⁶ Loc. cit.

⁷ Ber. a. d. k. saechs. Entbind. Inst. in Dresden, 1876-78. Leipzig, 1879, vol. iii, p. 217.

⁸ Étude sur l'apparition précoce de l'ophthalmie purulente chez les nouveau-nés, par Bellouard. Paris, 1892. Thesis.

⁹ Thesis, Paris, 1875. Cited by Bellouard.

¹⁰ North American Practitioner. Cited in Hirschberg's Centralbl., 1893, p. 557.

stilled immediately; within one hour after birth, when the child was washed, the nurse noticed that there was pus in the eyes, and called the attention of the resident physician, Dr. S. H. Allen, to it. I was called on the following day, and found the eyes discharging a yellowish fluid; there was not much swelling; there were opacities of both cornea, but no ulcers. The treatment consisted in the application of cold and silver nitrate. The child was discharged July 30th, with large opacities of both cornea.¹

These nineteen cases are all that I have been able to collect, though using great care; this indicates that intra-uterine infection is very rare.

When did infection occur in these cases? Probably soon after the rupture of the membranes, the infectious material being carried in most cases by the finger of the examining physician or midwife. In seven cases the rupture occurred between forty-eight and seventy-two hours before birth. In seven the time of rupture is not stated; in two it occurred from seventeen to nineteen hours before birth, and in one (Bellouard, 1) it took place within eight hours; in another (Haussmann) it is said to have occurred shortly before delivery, while in my own case it appeared to have taken place only three hours before. Haussmann assumed that the pathogenic agents passed through the unbroken membranes. Bellouard thinks that there was a lateral rupture of the membranes, sufficiently large to admit the entrance of the poison, but not permitting the entire fluid to escape, for the bag was distinctly felt eight hours before the child was born. In my case the inflammation had passed through the period of incubation, and there was pus in the conjunctival sacs at birth; infection must have occurred at least twenty-four hours before birth, and twenty-one hours before the amniotic fluid escaped. I am unwilling to accept Haussmann's explanation,² that the poison passed through

the unbroken membranes, and think it more likely that there is an error of observation, *i.e.*, that there was an earlier rupture than stated, with probably partial discharge of the fluid, as is assumed by Bellouard.

As the infection occurs at varying lengths of time before delivery we should expect to find the inflammation in different stages of development. This is actually the case. Thus, in some the inflammation began to show itself a few hours after birth, and in one the eyes were completely destroyed at birth.

The number of eyes that were thus lost by corneal involvement is exceedingly large. The result is stated in fourteen of the cases; in five of these the cornea escaped, but in nine corneal opacities resulted. Though the total number of cases reported is not large, still we do not hesitate to call this form of ophthalmia exceedingly dangerous. We would attribute the virulence of these cases in part to the prolonged contact of the eyes with the poison. In cases in which infection occurs during the short time that it takes for the head to pass through the vagina, the contact may be very short, and then the eyes are almost always immediately washed. The duration of contact in cases of intra-uterine infection may be hours or even days.

It is interesting to consider the question of prophylaxis as applied to these cases. The application of Credé's method would appear to us to be of service in those cases only in which the infection was very recent. Bellouard ascribes much benefit to it in Cases 12 and 15, but it was used in my case without benefit. Bellouard suggests the use of vaginal injections, especially in those cases in which the membranes rupture early. Pareschev used injections of mercuric chlorid (1:2000 or 1:3000) without benefit. Feis made frequent irrigations with one-and-a-half per cent. solution of carbolic acid, without preventing the appearance of the inflammation at birth; Dianoux applied mercuric chlorid (1:100) and silver nitrate (1:100) frequently in the form of vaginal injections, besides Credé's method, and still the ophthalmia developed ten hours after birth. Aside from the danger of the use of such strong solutions of mercury, it appears that their benefit is far from having been proved, though they would seem to be indicated.

This form of ophthalmia neonatorum is fortunately very rare, as is shown by the meager number of cases reported, as well as by the fact that such large statistical tables as those of Credé appear to be unaffected by it.

producing an inflammation similar to that due to the gonococci, though less intense and more rapidly cured. We are, however, unwilling to accept this explanation, and believe that direct infection took place, even though much care was exercised.

¹ Since writing this paper the following notes have been received from Dr. Edith Eareckson, of this city: She was called to attend a colored girl in her second confinement, March 17, 1893, and was informed that the membranes had ruptured eight hours before she arrived. The labor was tedious, there being a face-presentation, and the child was not born till seven hours later. At birth the eyelids were much swollen and tightly closed. When forced open to use Credé's preventive, silver nitrate, muco-pus jetted out. The eyes were washed as thoroughly as possible with a solution of mercuric chlorid, and a 1 per cent. solution of silver nitrate was dropped in. Nine hours later much pus was again found in both eyes. The condition of the cornea was not noted. After the fifth day the case passed out of her treatment, and nothing further was heard of it.

² This assumption is also made by Nieden, Zehender's Monatsbl., 1891, p. 353, to explain the appearance of an ophthalmia in an infant born in unbroken membranes. The child was taken out of the sac by the physician with the greatest care. And yet the eyes became inflamed in twenty-four hours in the characteristic manner, though gonococci were not to be found in the secretion. Nieden assumes that the amniotic fluid was infected by the diffusion of a poisonous substance which was capable of

**LOCAL ELECTROLYSIS AND ZINC-AMALGAM
CATAPHORESIS IN MALIGNANT AND NON-
MALIGNANT TUMORS.¹**

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BEFORE reporting the three cases on which this new treatment of morbid growths is mainly based I must explain what I mean by local electrolysis and zinc-amalgam cataphoresis, and also advance reasons for my belief that these methods, either separately or together, present important advantages over cutting operations in certain cases of benign vascular growths and incipient carcinomata.

Local electrolysis means simply that the electric decomposition of the tissue-salts is confined to a localized area by the approximation of the poles. If both poles of a galvanic current be placed in the morbid tissue quite near each other, the bulk of the current will be concentrated within the tissue immediately between them, and but little will traverse the outside healthy parts. In practice they should not be further apart than from a half to one inch, though this depends entirely on the strength of the current to be used and the size of the growth. So placed, an enormous current may be employed to dissolve a morbid tissue without affecting the surrounding tissues, the parts having been chilled by a spray or otherwise, if sensitive, rendered anesthetic. The surgical possibilities of such currents are quite remarkable. All the salts and liquids of a given growth lying between the points become a prey to such a current, the watery contents being turned into oxygen and hydrogen gases, and the complex salts into solutions of acids and alkalies. This is, of course, attended with a material rise of temperature, but nothing like charring. If the tissue subjected to the process is soft and vascular or juicy, there will be very little left between the poles after the gas has been given off, but the acids and alkalies dissolved in a turbid liquid remainder. If the tissue is tougher and more fibrous, a gristly residue will be found which can be detached or left to be detached by nature.

The strength of current required to destroy tissue in this way depends altogether on its concentration at the active spot. A minute reproduction of the process occurs when we apply but two or three milliamperes to the papilla of a hair-sheath or to a mole on the skin; but to dissolve completely tissues between two or more needles a half-inch apart requires a current of at least from 400 to 700 milliamperes.

¹ Read before the Philadelphia County Medical Society, January 9, 1895.

Whether this portion of my method has any advantages over a cutting operation in removing malignant or non-malignant external growths depends upon circumstances. It is clearly inapplicable to any growth within the body unless it is situated in a drainable natural cavity, as a considerable quantity of detritus must drain away. It also presents the disadvantage of not permitting healthy tissues to be united at once over the seat of the removed growth, a procedure, however, that is often of doubtful utility, as it frequently covers up portions of the disease that failed to be removed. The advantages of the method over the knife are, on the other hand, by no means inconsiderable. It is absolutely bloodless, no matter where applied, thus enormously conserving strength after operations notoriously bloody; the edges of the undestroyed tissue remain non-absorbent, lessening risk of sepsis; and finally there seems to be some property in the galvanic current to cause a retrogression of the whole of a benign growth, even when but a portion is directly acted on, as in the Apostoli treatment of fibroids, and the ordinary treatment of moles and other small skin-tumors.

If the growth be a benign one, the application described will probably cover the whole of the active treatment. If it be malignant, on the contrary, the second portion of the method—zinc-amalgam cataphoresis—is employed, a procedure of great value in radically removing all remaining traces of a still localized carcinomatous growth.

Zinc-amalgam cataphoresis is electrically monopolar, the single active electrode, which is always positive, being applied to the cavity left by the removal of the greater portion of the growth, while the indifferent or negative electrode, in the shape of large conducting pads connected together, is placed on any convenient part of the body. The active electrode is a freely amalgamated zinc surface of one or two square centimeters area, which is held successively against all portions of the bottom and edge of the excavation. From 150 to 300 milliamperes are sufficient, the pain being controlled by cocaine in solution placed in the excavation beneath the electrode, to be conveyed into the tissues simultaneously with the nascent zinc oxy-chlorid and mercury, which are dissolved from the electrode by electrolysis.

By this procedure we search out and destroy all remaining spurs and paths of infection in the contiguous unhealthy and healthy tissues, the current seeking vascular and cellular paths of less resistance by preference in its journey to the other pole; and to the lethal effect of the current we add the well-known lethal effects of nascent compounds of mercury and zinc. The surface of the amalgamated zinc electrode is consumed in the process—the mercury

as well as the zinc—producing a mixed infiltration of the immediate polar region that is readily detected by the eye. Low organisms in the immediate neighborhood of the electrode quickly succumb, and the antiseptic value of the procedure is shown in the correction of any odors that may have accompanied the carcinomatous discharge. That the action is not confined to the immediate neighborhood of the electrode was well demonstrated in one case in which the zone-like base of a carcinoma was observed to lose its induration and shrink in places distant at least an inch from the contact-point.

The applicability of the first portion of the method—local electrolysis—to a benign growth was shown in the following case :

CASE I. Large intra-uterine cystic fibroid destroyed piecemeal by repeated applications of bipolar electrolysis, resulting in a satisfactory cure.—Mrs. D., a nullipara, aged thirty-nine years, was referred to me by Drs. Hemminger and Bixler, of Carlisle, Pa., in September, 1892. Six or seven years previously Dr. Hemminger had discovered an intra-uterine growth, the lower portion of which was later found to be projecting from the dilated os, giving rise to pain and hemorrhage. Efforts to remove the growth by the écraseur were made by Dr. Hemminger, but, owing to its extensive internal attachment and great vascularity, only the projecting parts were removed. When I first saw the patient the tumor was nearly the size of an adult head, the upper limit being even with the navel. The mass was symmetric in shape, soft, and semi-fluctuating. Examination showed the os fully dilated, through which projected a portion of the tumor the size of a fetal head. Around this projecting mass several fingers could be swept, showing freedom from adhesion to the uterus for three inches anteriorly and about six inches posteriorly. The mass was evidently a vasculo-cystic fibroid situated within the cavity of the uterus and attached to the uterine walls throughout three-quarters of its periphery. It was spongy, but very tough, bled easily, and gave rise to a copious watery leukorrhea. The conditions presented by this growth, particularly its cystic degeneration, absolutely contra-indicated the ordinary Apostoli treatment of fibroids, on account of the danger of producing sepsis. I accordingly attempted its removal by morcelllement, using the scissors, the dull scalpel, and the fingers, but was compelled to desist, owing to the frightful hemorrhage. In this dilemma the possibilities of localized destructive electrolysis occurred to me, and it was begun by the use of a bipolar instrument having four prongs, two to each pole. These prongs were buried in the projecting portion of the tumor and a current of 700 milliamperes turned on for six minutes. This dissolved quite a hole in the morbid tissue, making the spot too hot for the finger. The procedure was repeated daily without hemorrhage or marked discomfort, as fresh portions of the growth were pressed down by the contracting uterus the possibility of sepsis being guarded against by a

continuous douche for an hour or more after each application. Three months were consumed in the eradication of the tumor in this way, though it doubtless could be done in a second case in a third of the time, the final examination showing nothing but a roughened spot on the anterior wall of the contracted uterus. External measurements now showed the upper limit of the uterus two-and-a-half inches below the navel. The cavity was capacious.

A letter from Dr. Bixler, dated February 26, 1894, stated that the patient was quite restored to health, complaining only of prolapse of the vaginal walls, the latter doubtless due to the descent into the pelvis of a uterus that had so long been within the abdomen. The cavity was still large, and there was some thickening of the walls on both the right and left of the uterus. The os would admit only the first joint of the finger.

In November, 1894, two years after the patient's admission, her husband called and reported that she was in good health.

CASE II. Sarcoma of tonsil and soft palate cured by local electrolysis followed by zinc-amalgam cataphoresis.—W. H. L., a blacksmith, aged thirty-eight years, was also referred to me by Dr. Hemminger, February 17, 1893. Five years before he had had an abscess of the left ear. Two years before being seen by me the left tonsil was found to be the seat of a tumor. He had recently been sent to the Hospital of the University of Pennsylvania, where he says malignancy was diagnosed and an operation urged, which he declined.

A tumor about the size of a goose-egg filled the pharynx, involving the tonsil and the soft palate, and threatening suffocation. Liquids only could be swallowed, and these with increasing difficulty.

The patient was placed on monopolar negative puncture with a current of from 30 to 60 milliampères daily. But little progress being apparent at the end of a week, the parts were cocainized, and on two occasions subjected to bipolar local electrolysis with a current of from 200 to 350 milliampères. The separation of the eschar that resulted was accompanied by some pain and reaction, but as the place healed it was seen that but a small portion of the growth remained. The man did not return for further treatment until more than a year had elapsed, during which he seemed to be well. At this time, however, a renewal of the growth occurred, and it was about the size of a peach-stone when he was readmitted to the Howard Hospital. During this second treatment zinc-amalgam cataphoresis was mainly employed, the treatment lasting six weeks, and being carried deeply into the base of the growth. A complete cure resulted, and at the examination of the parts six months later a healthy scar only was to be seen.

CASE III. Inoperable carcinoma of the groin greatly relieved by zinc-amalgam cataphoresis; death from erosion of femoral artery and vein.—Col. H., aged sixty-two years, was sent to me by Dr. A. W. Knox, of Raleigh, N. C., in the summer of 1893. One year before he had noticed a lump in the left groin. When first seen the tumor was the size of a large

walnut, of a bluish color, and firmly attached by a broad base to the deeper parts of the thigh. It was situated just below Poupart's ligament, and lay immediately over the femoral artery and vein, and was apparently attached to the latter, though the exact location of the artery was uncertain owing to the general induration.

At the patient's request it was decided to make a tentative use of electricity. The central and projecting portion was accordingly destroyed by local electrolysis, making a slight cavity into which a solution of cocaine was poured. Into this the blunt amalgamated zinc-electrode was pressed and daily applications of the cataphoresis made, with currents averaging 150 millampères. The immediate effect of the application was to whiten the edge of the growth in contact with the electrode, the whitened coating peeling off later. The indurated ring and base that now represented the growth was about three inches wide. Under constant applications the whole of this was gradually destroyed and replaced by healthy granulations, except the center of the base, where the close proximity of the large artery rendered the applications unwise. At the end of three months the diseased area had been contracted to the size of a five-cent piece, but there was a deep cavity extending down to the great vessels, where it was thought to be unsafe to apply the current. The patient had increased twenty pounds in weight, and though he had been brought on a stretcher, he was now able to walk a half-mile or more. During the continuance of this improved condition, however, the artery suddenly gave way one day at the bottom of the untreated spot. Drs. Thos. S. K. and T. G. Morton were called in consultation, and the former tied both artery and vein, which were found thoroughly infiltrated with carcinomatous material for some distance upward into the abdomen. Gangrene of the limb supervened, followed by death two weeks later.

An estimate of the value of the method in these three cases must be comparative, as cases similar to each are usually subjected to other methods, removal with the knife being the favorite. Hysterectomy in the first case would, of course, have involved removal of the ovaries also. Both this and removal of the uterus itself were avoided entirely, no natural structures being even injured, and the time required in the treatment was probably not longer than that necessary to recovery from the effects of abdominal section. In the second case the bloodless removal of a sarcoma of the palate was followed by a treatment of the neighboring parts that I hope will render the patient less liable to a return of the disease. The third case was, of course, a failure to cure or to preserve life, yet it is thought that life was prolonged by the very evident curtailment of the growth and improvement of health. Comparisons were hardly possible, however, as an operation had been refused by one surgeon as useless.

212 SOUTH FIFTEENTH STREET.

THE RELATIVE AGE-OCCURRENCE OF COLLES' FRACTURE—A TABLE OF NINE-HUNDRED-AND-EIGHTY-EIGHT CASES.

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In June, 1890, while serving as surgeon to outpatients at the New York Hospital, my attention was called to the large number of boys and young men who came under my care suffering with fracture at the lower end of the radius. A considerable proportion of the fractures were transverse; many were oblique, and had the typical deformity of the "Colles'" fracture. In many instances the injury had been diagnosed as a sprain, and the patient had been told to use the limb, when pain and disability, with, perhaps, increasing deformity, led the sufferer to seek advice at the hospital. So many boys and youths presented this lesion that I passed in review the cases which had previously been under my care at the Chambers Street Hospital, and gained the impression that the percentage occurring at this age is greater than is generally thought or taught. I believe that I am not wrong in saying that it is generally supposed that the Colles' fracture occurs most often in women, and in women between forty and sixty years of age.

An exact definition of Colles' fracture is not easily given. Originally the term was applied to those lesions at the lower end of the radius accompanied by the typical "silver-fork" deformity. This deformity may be pronounced, or it may be so slight as to be practically unnoticed. As a rule, the more oblique the line of fracture the greater the deformity. It is not infrequently seen, however, in cases in which the bony lesion seems on palpation to be practically transverse. In the greater number of cases the line of fracture is between one-half inch and one inch above the articular surface. It may be less or more than this. It has seemed wise to me, therefore, to include under the head of "Colles'" all fractures, completely traversing the radius below a point one-and-one-half or two inches above the articular surface.¹ This would include, of course, diastases.

As I have said, my attention was so strongly called to this frequency in boys that I looked up the cases treated at the Chambers Street Hospital between December, 1878, and June, 1888,² and those in the

¹ 1½ inches in children, 2 inches in adults.

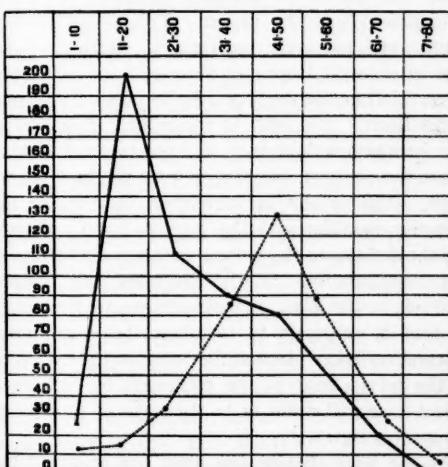
² If I remember rightly, this period was taken as representing the incumbency of Dr. Bull as chief surgeon. During a considerable portion of this time I served on the staff as house-officer and out-patient surgeon. The date of January, 1888, re-

out-patient department (second surgical) of the New York Hospital, between January, 1888, and June, 1890, the latter date representing the time at which the list was made. The result of this investigation is shown in Table A and the accompanying chart. It is seen that in males nearly one-half (201 cases out of 590) occurred in the second decade, while in females the greater number (132 out of 398) were found in the first decade. Attention is called to the proportion occurring in males, 590 cases out of 988.

TABLE A.

Ages.	Males.	Females.	Total.
1 to 10	37	11	48
11 " 20	201	13	214
21 " 30	110	32	142
31 " 40	88	86	174
41 " 50	79	132	211
51 " 60	52	87	139
61 " 70	21	28	49
71 " 80	2	9	11
Total	590	398	988

CHART.



The continuous line represents males, the dotted line females.

In this connection it may not be amiss to state the character of the districts which furnished these cases. The House of Relief of the New York Hospital (formerly known as the Chambers Street Hospital, now occupying the new building known as the Hudson Street Hospital) is situated in the lower part of New York, and draws its out-patients from a large and crowded tenement-house district, as well as from the immense factories and workshops and traffic-laden streets. The out-patient department of the New York Hospital in Fifteenth Street

presents my appointment at the New York Hospital, and the cases there are from my private notes. A few cases in private practice are included.

is recruited largely from the tenement-houses of the West Side. It is very possible that an equal number of these accidents occurring in private practice might furnish charts of a different character. My own private practice has, however, furnished a number of cases in patients under twenty years, of which the following may serve as an illustration:

In September, 1894, I was asked by Dr. J. W. O'Connor, of this city, to see W. E., a boy of eight years, who gave a history of having sustained an injury to both wrists some four weeks previously. He had been seen by the family physician, who had made a diagnosis of sprain, and had treated the case accordingly. Pain, disability, and deformity had led the parents to take the lad to Dr. O'Connor, who had recognized the true nature of the lesion. On examination both wrists were found the seat of Colles' fracture. The deformity was typical in each instance, the lower fragment being thrown back and to the radial side. The line of fracture seemed oblique, just above the carpal articulation. There was firm union. Ether was administered, and vigorous attempts made to rebreak, but without avail. In view of the moderate degree of the deformity osteotomy was thought inadvisable.

I have seen other similar cases in which a diagnosis of sprain had been made. It is not improbable that what would seem, after union had taken place, to have been an oblique fracture was originally a transverse diastasis, but that early use, before union, has thrown the lower fragment backward. In this way patients who return to work too early may occasion a marked deformity.

We should, then, carefully examine young people with injured wrists for fracture. The diagnosis can generally be made, if seen early, by obtaining false motion and a soft crepitus. In some cases, however, it may be difficult. As Stimson says: "In difficult cases, fat people and children, without displacement, it may be made upon the existence of a well-defined transverse line of tenderness, or pressure on the dorsum of the radius, deepening of the transverse folds on the palmar aspect of the wrist, loss of power in the limb, and history of the case." The only table with which I am able, at this time, to compare my own is that quoted by this author (*Treatise on Fractures*, p. 323). In this the fractures of the entire radius are given:

Ages.	Males.	Females.
0 to 5	62	64
5 " 15	92	19
15 " 30	78	45
30 " 45	75	57
45 " 60	45	123
Above 60	21	87
	373	395
Total	768	

The accompanying chart represents cases which returned to the hospital for treatment. A considerable number in addition had a single dressing applied, and failed to reappear. I do not assume that it is to be accepted as conclusive, and simply offer it as a contribution to a subject of much interest, and hope that surgeons who have access to the records of a considerable number of cases may be led to place their statistics on record.

A CONTRIBUTION TO THE STUDY OF OCCIPITO-POSTERIOR POSITION OF THE VERTEX.

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THE notes forming the basis of this paper are the result of a detailed study of twenty-nine cases of vertex-presentation, with the occiput to the back. In each particular instance the diagnosis was confirmed by other physicians after labor was fully established. A brief analytic study of the cases in question shows that twenty, or more than two-thirds of the entire number, rotated to the front, unaided by any manual interference whatsoever, and were delivered normally, with the occiput under the pubes. Of the nine in which spontaneous rotation did not take place, one was complicated by a prolapsed cord, demanding immediate podalic version and extraction. Another occurred in a pelvis having a conjugata vera of but three-and-a-half inches. In this case the occiput was twice manually rotated to the front and axis-traction forceps applied, but all efforts at delivery failed. Internal podalic version under complete narcosis was then elected, easily accomplished, and a successful extraction followed.

Of the seven cases not already considered, three were forceps-operations at the superior strait, with the head but partly engaged. In the remaining four the head had descended to the pelvic floor, with the occiput in the hollow of the sacrum. In all of these instrumental cases, save one, the occiput remained persistently to the back; hence the frequent occurrence of tears in the pelvic floor. These lacerations of the vagina, levator, and perineal body were immediately repaired, special care being taken to approximate the deep muscular structures. Union by first intention occurred in 85 per cent. of the cases operated upon. In but one case was the child still-born. From the foregoing facts it will be seen that a large majority of posterior positions of the occiput are delivered without the obstetrician's interference, after anterior rotation has taken place. In cases ending thus favorably there is but little added danger to either mother or child. Spontaneous rotation may occur at the superior strait, in the cavity

of the pelvis, or on the pelvic floor. From a considerable experience in midwifery I am led to believe that this malposition—for such it is—is of much more frequent occurrence than is generally conceded by most authors, as many of these posterior cases remain unrecognized, owing to the difficulty in diagnosis during the early stages of labor. Again, a large percentage rotate to the front unaided, and are recorded as anterior positions; hence the statistics on this subject are of little value.

An existing disproportion between the head and pelvis is not infrequently met with, preventing proper flexion and engagement, so that dystocia follows, and operative delivery is very often too late to be successful; hence the need of early and accurate diagnosis. Furthermore, the forceps should never be applied until such relations have been carefully determined and possible malpositions corrected. To recognize these conditions after labor is established and a caput formed presents no little difficulty; hence I urge that when there is doubt as to the exact relation that a head bears to a particular pelvis, the patient be chloroformed and the aseptic hand passed into the uterus. This procedure will at once end any such uncertainty. With the hand thus introduced improper flexion of the head may be rectified or the occiput may be manually rotated to the front. It is well to remember, if such rotation be attempted, that it is necessary not only to rotate the occiput, but also to turn the body to the front. This is best accomplished by grasping the posterior shoulder with the internal hand and turning the dorsum to the front; external aid facilitates this manipulation. Early diagnosis and postural methods in this class of malpositions are frequently all that is necessary to terminate labor normally. As rotation takes place at the brim, in the cavity, or on the pelvic floor, so the treatment of each individual case will differ as to the stage of progress in the mechanism.

At the brim (before the head has engaged) the employment of postural methods frequently results in the normal termination of labor. The patient should be placed in the left or right latero-prone position, depending on whether the child's dorsum and occiput point toward the left or the right side of the mother. In one of the cases making the basis of this paper, use of the Trendelenburg¹ posture aided very materially in preserving the normal mechanism. This position offers all of the advantages of the genu-pectoral without the discomforts of the latter to both physician and patient. Should these methods fail, manual rectification or podalic version may be elected. The former procedure deserves consideration when the pelvis is ample, and the

¹ As suggested by Dr. Fry, of Washington, in the management of mento-posterior cases, May, 1894.

dorsum, as well as the occiput, can be rotated to the front. This failing, or should the occiput, after being once turned anteriorly, again rotate to the back, complete podalic version should at once be instituted, not waiting until the amniotic fluid has entirely escaped, and the operation be complicated by a spastic uterus.

Should any disproportion exist between the head and the pelvis, version may be elected. The extraction of the after-coming head through a flattened pelvis of slight degree is more easily accomplished, by reason of the overlapping of the parietal and underriding of the occipital bones, than the delivery of the fore-coming head under like circumstances. The application of forceps to a head floating about at the superior strait, whether of an axis-traction model or not, is a procedure that deserves the condemnation of careful obstetricians.

In the cavity of the pelvis (when the head has entered the superior strait and is descending, the occiput being shunted to the back by the incline of the levator-ani muscle) rotation may be promoted by keeping the patient in the latero-prone position, having her lie on the side toward which the occiput points. Since beginning this paper I have had two opportunities to utilize a method suggested by Penrose in the management of mento-posterior positions, *i. e.*, the whole hand is introduced into the vagina, the palmar surface corresponding to the position of the occiput. The palmar surfaces of the fingers act as a lateral inclined plane, shunting downward, forward, and inward, while the thumb pushes the sinciput upward and backward, promoting perfect flexion and rotation. This manipulation should only be employed during the pains. Should impaction occur, the axis-traction forceps may accomplish delivery, the head rotating during its descent. I must take issue with the few who forcibly rotate the occiput to the front while the head is well down in the pelvic basin, as at this stage simultaneous rotation of the shoulders is not apt to occur without a dangerous amount of torsion of the neck. When delivery is found to be impossible because of impaction of the occiput in the hollow of the sacrum, symphysiotomy or craniotomy may be elected according to indications.

With the head on the pelvic floor (at the vaginal outlet) the occiput can, in a very large proportion of the cases, be rotated to the pubes "by backward pressure with the fingers against the anterior temple, combined, if necessary, with forward pressure upon the occiput." Should this method fail, rotation may usually be accomplished with a short pair of straight forceps.

Forceps to a posterior vertex as such, with the head on the pelvic floor, is not a difficult operation,

though the mechanism and direction of traction must be very closely observed.

Short, straight forceps accomplish delivery most readily. The traction is made directly forward until the root of the nose is immediately behind the pubic arch. The line of traction is then changed to the third position, perfect flexion of the head being preserved by upward pressure against the sinciput with the thumb, while a finger of the same hand in the rectum aids in shelling out the head by dislodging the occiput.

CLINICAL MEMORANDA.

ERYSIPelas AS A COMPLICATION OR SEQUELA.

By J. R. JOHNS, M.D.,
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THE importance to the physician of a knowledge of the inherent pathologic proclivity of a given patient, aside from any present disease, cannot be too strongly emphasized. Heredity, though losing ground as a clinical factor since the advent of germ-pathology, must not be underrated. Cachexy or diathesis may be obscure, yet none the less powerful in shaping pathologic processes when intercurrent disease has lowered the system's vital tone. Co-existent with and interdependent upon the malady we are called upon to treat, this deep-seated morbid trend determines the erratic course of disease, it may be causes a fatal issue or simply retards convalescence, all the time probably unrecognized. Important among such tendencies, not to speak of obvious pathologic states of the same, are struma in the young; and in the adult pulmonary tuberculosis, malaria, and that to which special attention is here called, viz., erysipelas.

Since the advent of influenza, five winters ago, I have observed several persons in whom erysipelas occurred as a complication or sequel, the primary affection always being atypical. In all these cases the persons were subject to recurrent attacks of erysipelas.

I propose to detail three distinct attacks that occurred in the same person, giving prominence to the features alluded to.

M. R., forty years of age, the mother of six children, was portly, but had, in general, good health. Independent of the malady in question she enjoyed the immunity from disease of the average of her age. She was prone to have an occasional attack of erysipelas, always of some part of the head. So was her mother, and also her mother's mother. Previously to my meeting her she had two or more attacks.

The first attack to which attention is called occurred during the epidemic of influenza, in January, 1892. In common with the rest of the family she contracted the disease, of a mild type. When convalescence was expected she took to bed with a chill, marked fever, and profound constitutional depression. The local lesion appeared on the hairy scalp; but was, however, insignificant when compared with the systemic disturbance. Being in the eighth month of pregnancy, premature labor was feared; and, indeed, painful contractions oc-

curred at intervals during thirty-six hours. This was successfully averted, however, by the use of quiet and opium.

In due time convalescence came, and later a perfect child was born at full term. Though the woman was in labor for twenty-four hours, and required forceps to effect the delivery, convalescence after labor was uninterrupted and complete.

In August of the same year she was taken with acute tonsillitis, for which the usual remedies proved speedily efficacious. Febrile action had ceased, and the tonsils had again apparently returned to their normal condition, when, on the fifth day, there was an unusual development in the case, marked by chill, hyperpyrexia, violent headache, and great swelling of the fauces. At once the tonsils showed a thick white coat in patches. The question of immediate isolation seemed paramount; but suspecting an invasion of the old trouble I deferred the diagnosis to the sixth day, meanwhile placing certain restrictions upon the rest of the family.

On the sixth day high fever, great depression, at times a muttering delirium, foul breath, approximating tonsils, and difficult respiration were the symptoms that marked the case. The question was: Erysipelas of the fauces or diphtheria, which? Knowing the morbid proclivity of my patient, and taking into consideration the shade of the swelling, her age, the mode of attack, and the facility with which the coating was detached from the tonsils, I pronounced the case one of erysipelas of the fauces. The developments in the case confirmed my diagnosis. Sustaining treatment, soothing local applications, liquid food, quiet and rest, were followed by complete recovery.

In connection with this case I recall the following episode: The hamlet was greatly alarmed. Many feared an outbreak of diphtheria, and scrupulously kept aloof. One old gossip, a large-hearted soul, was a frequent caller, and even ventured to supplement treatment. On returning to the quiet bed-chamber one morning I at once detected more than the fetor of the patient's breath. Upon inquiry I was informed that Mrs. M. had applied a poultice which was known to be highly valuable in such cases. Her poultice consisted of freshly-dropped hog manure. I need not add that as soon as enough light and vent could be had this "animal extract" was hurled to the street below.

During February of the past year I was called to deliver this woman of her eighth child. Labor was normal, but convalescence was slow and discouraging. Tenderness and sharp pain centering in the right inguinal region, accompanied by a mild degree of fever, appeared the first day and continued four days. Calomel and sodium bicarbonate, $\frac{aa}{2}$ gr. ss., with acetanilid, gr. iv, repeated every two hours, removed all pain. The stools became frequent, liquid, and bloody; and continued so in diminishing degree for several days. The temperature became normal on the fourth day. At this time there was a slight chill and return of fever, which continued one week. With the return of the fever she began to complain of soreness of the tongue. This was mainly on the right side, where a broken molar tooth had irritated the organ. Her continued weakened state kept me on the alert for an outbreak of erysipelas which had now appeared in the form of erysipelatous glossitis. On the second day after the chill, as I entered the room, the

patient informed me that the old trouble had returned; "for," said she in muttered speech, "I can taste it." Inspection confirmed her diagnosis. The tongue was uniformly involved and now completely filled the mouth. The lesion was strictly confined to the tongue. Treatment similar to that employed in the attack of erysipelas of the fauces was instituted, and in the second week she was again found mending.

My knowledge of this proneness to recurring attacks of erysipelas in this patient, as in others to which I can but allude here, enabled me to employ early those supporting measures upon which life depended. How to explain the etiology and the apparent heredity of this proclivity in the light of accepted pathology are questions for others.

CARCINOMA OF THE RIGHT MAXILLARY ANTRUM.¹

BY ARTHUR H. CLEVELAND, M.D.,
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R. T., a colored woman, whose age was not exactly known, but who was probably in the neighborhood of sixty years old, was first seen at the clinic of the Presbyterian Hospital on March 13, 1893. She gave a history of nasal trouble of over three months' duration, during which time she had been under constant treatment elsewhere, and had been several times cauterized. There was stoppage of the right side of the nose, with considerable discharge, both muco-purulent and crusty. Coincidently with the nasal trouble, she said, she began to have pain in the right ear, with dulness in hearing. The pain extended to the back of the neck, and there was stiffness of the jaw, with pain on opening the mouth widely. The patient claimed to have had no nasal trouble previously to this attack. The family history was hard to obtain and unsatisfactory.

Examination showed the right nostril filled with mucus. The lower turbinate was somewhat enlarged, but the middle turbinate was much enlarged and inflamed. A posterior view was not obtainable. The pharynx was not much congested. The right membrana tympani was considerably thickened; the left thickened and opaque, and in the posterior lower segment, below the malleus handle, were some chalk concretions.

As the last "burning" had been but recently done I attributed the inflammation to that, and prescribed a weak alkaline wash, to be used twice daily.

On March 29, 1893, the patient returned, still complaining of the discharge and stoppage. The inflammation seemed to have decreased, and attached to the right middle turbinate posteriorly was what appeared to be a large raspberry polyp. Its removal by the cold snare was followed by copious epistaxis, not, however, sufficient to be alarming. The nostril was plugged with gauze for a short time, but this was soon removed.

The sensation afforded by the snare while cutting through the growth was peculiar and hard to describe, but very characteristic. It was as if the tissue was emphysematous and the fibers brittle.

¹ Read (by invitation) before the Laryngological Section of the College of Physicians, December 11, 1894.

The polyp showed nothing peculiar except that there were some evidences of inflammation and small connective-tissue trabeculae running through it.

Microscopic examination was not made.

On April 3, 1893, the woman again returned with the discharge persistent. Examination showed the middle turbinate still swollen and very much inflamed. There had been one or two attacks of epistaxis, not of long duration, but very free while they lasted. The aural pain still persisted. She was again given a nasal wash, hoping that a few days would reduce the inflammation and allow more extended examination.

The patient did not return after this, and on the first of May the dispensary nurse looked her up, finding her at home and in bad condition.

She was immediately brought to the hospital and admitted to Dr. H. R. Wharton's ward. Through his kindness I was enabled to see her there. The first visit confirmed to my mind the diagnosis of carcinoma, which I had before guardedly made. There was swelling of the entire right side of the face; the right eye was prominent, and the lids edematous, with considerable conjunctivitis and discharge, owing to inability to close them. The pain in the ear was still severe and persistent. The temperature varied slightly from 99°. Operation was thought inadvisable, and the patient gradually sank and died from exhaustion on May 12th.

The autopsy was made by Dr. H. W. Cattell, and from his notes, supplemented by later examination of the specimens, which I was privileged by the family to remove, we obtain the following:

A large extra-dural mass involved the neighborhood of the sphenoid bone superiorly, extending anteriorly to the crista galli and the orbital plate of the frontal bone on the right side. Posteriorly it extended nearly to the anterior margin of the petrous bone. The sella turcica seemed broken down and incorporated in the mass, which was of a soft consistence, and was infiltrated with pockets of sanguous pus. The right optic foramen was much enlarged and the bones disorganized. The eye on that side was diseased, shrunken, and discharging pus. The optic nerve in its backward course penetrated the mass of new growth and soon became unrecognizable. The cavity of the tympanum was not affected, the bones and membrane being intact. Below, the right maxillary antrum was filled with a gelatinous mass mixed with pus. The bony walls were apparently sound except posteriorly, where they were eroded. The lower turbinate was not enlarged anteriorly, but posteriorly had reached a large size. The middle turbinate was much involved, being enlarged in its whole extent. The septum was not affected. The growth and position of the mass pointed to an origin in the antrum. Microscopic examination of a specimen from there showed it to be a carcinoma.

108 S. SEVENTEENTH STREET.

Meharry Medical College.—The nineteenth annual commencement of Meharry Medical College, the ninth of the dental department and the sixth of the pharmaceutic department of the Central Tennessee College, were held on February 5th, at Nashville, Tenn. There were twenty-nine graduates in medicine, two in dentistry, and five in pharmacy, and the interesting feature is that all were colored men.

A CASE OF FORMATION OF A NEW LID BY TRANSPLANTATION OF SKIN WITHOUT PEDICLE (WOLFE'S OPERATION).¹

BY HOWARD F. HANSELL, M.D.,

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CHIEF OF CLINIC OPHTHALMOLOGICAL DEPARTMENT, JEFFERSON MEDICAL COLLEGE HOSPITAL, ADJUNCT PROFESSOR OF DISEASES OF THE EYE, PHILADELPHIA POLYCLINIC.

IN February, 1893, X. Y., a married woman of intemperate habits, applied at the Out-Patient Eye Department of the Jefferson Medical College Hospital, during the service of Prof. William Thomson, for relief of an extremely disfiguring deformity of the upper lid of the left eye. Several months previously, while temporarily unable to control her movements, she fell down a short flight of steps, striking the left side of her face against a hard substance and breaking the skin. Erysipelatous inflammation and abscesses followed. After recovery the upper lid of the left eye was completely everted and held fixed in its new position by a firm, dense, horizontal, linear cicatrix, which united its ciliary border to the skin beneath the supra-orbital margin, entirely obliterating the normal exterior lid-surface. The conjunctiva was thickened, indurated, and congested from constant exposure to wind and atmospheric impurities. The cornea remained clear, vision good, and no disturbance of the function of the eye was found. While undecided as to the best method of operation, I had the opportunity, through the courtesy of Dr. G. E. de Schweinitz, to examine a case in which he had transplanted a piece of skin without a pedicle after the removal of an epithelioma involving the entire lower eyelid. (*Transactions American Ophthalmological Society, 1894.*) The result had been so satisfactory after the lapse of nearly a year that I determined to attempt a similar operation. Accordingly, a few days later, under ether, I loosened the ciliary border of the lid from its abnormal attachment, excised the cicatrix into which the skin of the upper lid had been transformed, restored the lid to its normal position, and retained it by stitching the margins of the two lids together. Thus the denuded surface was stretched and its folds obliterated. The surface thus exposed measured about 20 mm. vertically and 25 mm. horizontally. From the inner aspect of the thigh a flap of skin 35 by 40 mm. and as deep as the subcutaneous tissue, but not including it, was removed, having previously been thoroughly cleansed by ablutions with warm water and soap and made aseptic by mercuric-chlorid solutions. The excised portion of skin was subjected to no intermediate treatment, but was at once transferred to its future site, and carefully spread, so that there was an overlapping of about 5 mm. on every side. The free border was then sutured in the adjacent healthy parts, and the whole covered with a moist mercuric-chlorid dressing, and held by a roller bandage. The wound on the thigh healed, without interruption, by granulation. Union between the transplanted and the underlying tissue, fostered by the immovable and continually expanded position in which the lid was held by the sutures, seemed to commence from the outset, and grew more firm daily. The overlying edges shrivelled and blackened, and, in a few days, were trimmed off

¹ Exhibited before the Section of Ophthalmology of the College of Physicians, November, 1894.

and the sutures removed. The result is excellent. At present, ten months after operation, the only noticeable defects are the slightly lighter color of the flap, as compared with the adjacent skin, and the presence of a few fine hairs. The patient suffers no inconvenience whatever, although, on account of a shrinking of a third of the original area of the transplanted tissue, she cannot completely close the commissure.

Contraction of the graft, which is the only disadvantage of operating by Wolfe's method, does not seriously modify the result when performed on those portions of the body where there is naturally a redundancy of skin and connective tissue, since its place is supplied by neighboring parts. Death of the epithelium, noticed by some operators, was not a feature in my case, and, if it occurred, escaped observation. The superiority of this over operations with a pedicle lies in the achievement of a good result with a minimum deformity, and is applicable especially to exposed surfaces.

NEW DEVICE.

A NEW INSTRUMENT FOR MARKING THE SKULL IN BRAIN-OPERATIONS.

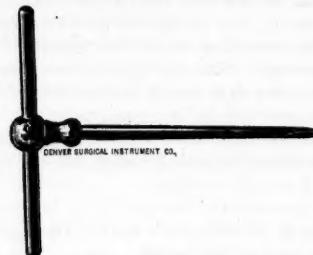
BY CLAYTON PARKHILL, M.D.,
OF DENVER, COLO.,

PROFESSOR OF SURGERY IN THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF COLORADO, VISITING SURGEON TO ST. LUKE'S AND THE ARAHOMA COUNTY HOSPITALS, MEMBER AND EX-PRESIDENT OF THE COLORADO STATE BOARD OF MEDICAL EX-AMINERS, ETC.

WHILE operating in a case of brain-tumor several years ago I was making use of a small drill to mark the skull in conformity with the measurements that had been made upon the scalp. To my surprise, and at the same time chagrin, the instrument passed directly through the skull and was driven into the brain. On removing the button of bone I found that, owing to the pressure of the tumor the skull had atrophied until it was scarcely thicker than an egg-shell. This experience, however, taught me that the instrument was not the proper one for making the markings. Larger drills are objectionable on account of the laceration of the soft tissues. Again, I have been embarrassed on several occasions by the fact that it was difficult to distinguish the marks made on the skull by the point of a drill from the foramina in the bone. I have had the Denver Surgical Instrument Company make for me an instrument for this purpose, which is shown in the accompanying cut. It consists of a shaft 9 cm. in length with a cross-bar handle 8 cm. The end of the shaft is divided into two portions or legs, one projecting beyond the other to the extent of 1 mm. This longer leg is made triangular, like the stylet of a trephine. The shorter leg, which is separated by two mm. from the longer one, is pointed, and its right side is knife-edged.

To use this instrument it is thrust through a small puncture in the scalp made with a scalpel. By turning it from left to right the longer leg becomes engaged in the bone and the short leg swings about this point as a center and describes a circle. The action is identical with that of a carpenter's compass. The knife-blade of the short leg is made in order that it may cut the periosteum as it is turned.

The advantages in using this instrument are: 1. It is thrust through a very small, clean-cut wound in the scalp. 2. The instrument is sufficiently large, so that it would be pure carelessness if it were thrust through even the thinnest skull. 3. It makes a mark that cannot be mistaken for anything else.



I have used this instrument in quite a number of brain-cases in the last two years, and I have found it to be eminently satisfactory. I take pleasure in commanding it to the profession.

MEDICAL PROGRESS.

Successful Trephining for Right Hemiplegia with Epilepsy.

WOOD and COTTERELL (*British Medical Journal*, No. 1775, p. 10) have reported the case of a girl, three-and-one-quarter years old, who presented weakness and inability to use the right hand, arm, and leg, together with a history of epileptic attacks. At the age of one year, the child had fallen from the top of a hay-rick, without immediately bad results. In the course of a few weeks, however, what appears to have been an epileptic seizure occurred. She fell, became unconscious, and lost power in the right arm and leg. Some six months later, two other seizures of similar kind occurred, and several again one year after this. The convulsive movements always commenced in the right thumb and fingers. On examination it was found that the left supraparietal region was distinctly flattened and sloping straight away from the vertex, the parietal eminence appearing to be pushed down and becoming more abruptly prominent than upon the opposite side. The eyes presented no lesion. The right arm was shorter than the left and cold and bluish-red in color. The movements were confined to flexion at the elbow-joint, which was necessarily limited by the general rigidity of the limb. The thumb was held across the palm of the hand, and, like the fingers and wrist, remained strongly flexed. The leg was rigid, the foot inverted, and walking could only be accomplished with great difficulty and with support.

An exploratory operation was decided upon and a semicircular flap, four inches long, was reflected up from the left parietal region. The periosteum was raised over an area of about two inches, the center of which corresponded to the middle of the flattened region. A disc of bone was removed by means of a three-fourths inch trephine from a point corresponding to the middle of the fissure of Rolando. The opening thus made was enlarged with cutting forceps. The dura mater was opened, and directly underneath there appeared a small cyst filled with serous fluid, situated apparently under or between the layers of the arachnoid. The dura mater

was thickened over the cyst and adherent in places. The adhesions were separated and two pieces of the external wall of the cyst were removed. The dura mater was stitched up, except at the lower angle, a cat-gut drain inserted and the wound closed. The child was collapsed after the operation, but quickly rallied. The wound healed by first intention, except in the track of the drain. A large amount of cerebro-spinal fluid escaped through the dressing for three or four days, but the wound was completely healed in the course of nine days after the operation. The child rapidly improved, notwithstanding attacks of whooping-cough and chicken-pox. Six weeks after the operation the child was able to walk without support. The hand could be opened spontaneously, and no fits had occurred. The improvement steadily continued until there remained very little of the hemiplegic condition.

Removal by Celiotomy of a Sarcoma of the Right Kidney from a Child a Year-and-a-Quarter Old.—GÖRL (*Centralblatt für die Krankheiten der Harn- und Sexual-Organe*, 1894, No. 10, p. 530) has reported the case of a boy, who, when eight months old, began to fail in health, and in whom the mother observed a sense of relative hardness upon the right side of the abdomen. There was also constipation, and to this was ascribed the abnormal physical condition. When the child was fourteen months old, a tumor was distinctly visible. This gradually increased in size, and there became superadded pain, emaciation, and debility. The tumor was oval, elastic, and movable, both laterally and vertically. It was easily separable from the liver, and did not move with the diaphragm in respiration. It could readily be felt to originate from the posterior wall of the abdominal cavity. The urine presented no abnormality, but the diagnosis of malignant growth of the kidney was made. Operation was undertaken when the child was sixteen months old, and the symptoms had existed for eight months.

In view of the not inconsiderable size of the neoplasm, its removal through the peritoneal cavity was undertaken. After the abdominal cavity had been opened by an incision along the outer margin of the right rectus muscle, from the costal margin almost to Poupart's ligament, the peritoneum covering in the anterior surface of the tumor was incised, and the peritoneal covering dissected off with the fingers. The growth was now brought to the abdominal opening and its posterior coverings split. The ureter and the renal veins were ligated, and the hilus divided. The tumor was removed, and the abdominal wound closed and appropriately dressed. The operation occupied but a quarter of an hour, and was well borne by the little patient. The excretion of urine was distinctly increased, and so continued for four weeks. At first the secretion contained some blood.

The further course of the case was favorable, so that the sutures could be removed on the tenth day, when primary union was found to have taken place.

For the protection of the line of the abdominal wound a binder was worn for a number of weeks. The condition of the child rapidly improved, and the patient appeared perfectly well five months after the operation. He was able to run around eight weeks after the operation.

The removed neoplasm was somewhat pear-shaped, and had a diameter of five-and-a-half inches. At its superior pole were the remains of the kidney. Histologically, the new growth presented the appearance of a small round-celled sarcoma.

Two Cases of Hysterical Blindness in Males, with Recovery.

—BARKAN (*Festschr. zum 25 Jähr. Jubiläum des Vereins Deutscher Aerzte* 1894) has reported two cases of complete blindness in hysterical men, with recovery. One occurred in a mine-engineer, thirty-two years old, in whose hands a jar of tomato-catsup exploded in the process of opening. The patient was struck in the face and eyes by fragments of glass, and, in attempting to reach a source of water for the purpose of removing the blood, his foot slipped, and he fell and lost consciousness for some hours. On returning to consciousness he was unable to see. There was also complaint of severe occipital pain. Under treatment with morphin, and blisters to the temples and behind the ears, light-perception and a slight degree of vision were restored. The eyelids were closed spasmodically, so that cocaine had to be employed to facilitate examination. It was found that the right eye had been wounded at the corneo-scleral margin, where the iris had become adherent, so that the pupil was pear-shaped, and reacted but slightly to light. The media were clear and the eye-ground normal. The left pupil was slightly dilated and reacted doubtfully to light. The media and fundus were also normal.

In the absence of organic change sufficient to account for the loss of sight, the diagnosis of hysteria was made and a favorable prognosis given. Injections of strychnin, gr. $\frac{1}{15}$, were prescribed, together with applications of the constant current, and iron, nutritious diet, systematic out-door exercise, cold sponging and massage. The black covering that had been used to protect the eyes was replaced by dark glasses. Improvement soon set in, but was temporarily interrupted by an interruption in treatment. This was, however, subsequently resumed, and the patient progressed to final recovery.

The second case occurred in a steward, thirty years old, who, after the ingestion of medicine furnished by a druggist for the relief of pains in the hips and arms, at once noticed impairment of vision. Several months previously vision in the right eye had been lost, and subsequently that in the left eye became dull. There was also severe and constant pain in the left eye and left half of the head, aggravated by the recumbent position and flexion of the head. The right cornea presented a central cicatrix and a turbidity of the capsule of the lens in a corresponding situation, both of which were ascribed to an ophthalmia during infancy, followed by corneal ulceration and perforation. The media and fundus were normal in both eyes. Improvement soon followed applications of the constant current.

Subcutaneous Torsion of the Spermatic Cord for Prostatic Hypertrophy.—RICHMOND (*British Medical Journal*, No. 1780, p. 339) suggests as a substitute for orchectomy for the relief of prostatic hypertrophy *bistournage* or subcutaneous torsion of the spermatic cord, with the view of cutting off the blood-supply of the testis and causing its subsequent atrophy.

THERAPEUTIC NOTES.

The Treatment of Diphtheria with the Antitoxin.—WITTAUER (*Therapeutische Monatshefte*, 1895, Heft 2, p. 67) has reported the employment of the antitoxin in the treatment of thirty-six cases of diphtheria, with five deaths. In addition the following solution was employed as a gargle: Solution of ferric chlorid, 5 parts; glycerin and absolute alcohol, each $7\frac{1}{2}$ parts. Of this fifteen drops were added to a glass of water.

At a recent meeting of the Ophthalmological Society of the United Kingdom JESSOP (*British Medical Journal*, No. 1780, p. 304) reported two cases of diphtheric conjunctivitis successfully treated with the antitoxin. The first was in a boy, nineteen months old, who presented membrane upon the upper and lower palpebral conjunctiva of the left eye, and a patch of membrane on the left side of the uvula; a lymphatic gland over the parotid was enlarged, and the urine contained albumin. Three injections of Klein's antitoxin were given, one-and-one-half drams in all. The membrane disappeared in five days, and left no conjunctivitis or other conjunctival change. In the second case, in a male child, eight months old, there was membrane on the palpebral conjunctiva of both eyes; the parotid lymphatic glands were enlarged, and there was a muco-purulent discharge from the nose. Two injections of Klein's antitoxin, one dram in all, were given, and the membrane disappeared in four days. Examination of the membrane in both cases disclosed the presence of diphtheria-bacilli.

Of 330 children received at the Hôpital des Enfants Malades in Paris, 258 of whom were recognized as diphtheric and were treated solely with the antitoxin and tonics, 31 died (12 per cent.). Of the fatal cases, eight died within twenty-four hours of admission and without having had time to receive the treatment.—*Lancet*, No. 3728, p. 377.

At a recent meeting of the Royal Medical Society of Vienna MONTI (*British Medical Journal*, No. 1781, p. 385) related that he had treated 25 cases of diphtheria with the antitoxin, with but a single death.

HEIM reported that of 27 cases of diphtheria similarly treated from October 6 to November 4, 1894, six died (22 per cent.), while among 236 cases treated during the year previously by other methods the mortality was 52.4 per cent. The average mortality for ten years ending with 1894 was 51.1 per cent.; the lowest rate was 25.9 per cent. in 1886, and the highest 58.7 per cent. in 1892.

UNTERHOLZNER stated that he had treated 37 cases between October 11, 1894, and January 10, 1895, with the serum, with eight deaths, five of which occurred within twenty-four hours of admission. He presented tables showing that among 31 cases treated with the serum there were eight deaths (25.8 per cent.), while among 36 cases treated without serum there were twenty-four deaths (66.6 per cent.). The second group included many mild cases.

KOLISKO (*Wiener medizinische Blätter*, 1895, No. 5, p. 75) reported the results of 75 post-mortem examinations of children dead of diphtheria and treated with the antitoxin. There was no doubt of the favorable influence of the treatment upon the diphtheric process. If a sufficient dose was employed and a

reasonable time had elapsed, rapid and equable exfoliation of the membranes was to be observed. The changes were most striking in cases of descending croup. The membranes were readily detached, because the administration of the antitoxin checked the formation of the toxins upon which the production of fibrin depended. The varying severity of the process was not believed to be an expression of various forms of the disease, but rather of various stages, as the process may have been long unobserved in circumscribed areas. The degenerative changes in the heart and the renal affections did not differ from those of ordinary occurrence. The local reaction at the seat of injection was so variable as to suggest differences in the fluid used. As direct results of the injection a streptococcus abscess and a phlegmon were observed. Cultivation-experiments in a case of erythema yielded negative results.

Among 30 cases of diphtheria treated by RAUCHFUSS (*Lancet*, No. 3729, p. 451) with the antitoxin, 19 recovered and 11 died (36.6 per cent.), while among a similar number treated during the same period with other measures the mortality was 52 per cent.

ESCHERICH (*Münchener medicin. Wochenschr.*, 1895, No. 7, p. 155) has treated 51 cases of diphtheria with the antitoxin, with five deaths (9.5 per cent.). Three of the fatal cases were in a hopeless condition when they came under observation.

The Treatment of Eclampsia.—GUBAROFF (*Centralblatt für Gynäkologie*, 1895, No. 5, p. 127) recommends a mode of treatment that he has successfully employed in six cases of eclampsia, three of which presented grave symptoms. The treatment consisted in the administration of narcotics, principally morphin in moderate but frequently repeated doses (gr. $\frac{1}{4}$ subcutaneously about six times in the twenty-four hours, according to the amount of urine); enemata of chloral, and only during operative procedures (including catheterization) mild chloroform-narcosis. All measures tending to stimulate the activity of the skin or to replace this vicariously were freely resorted to. These included warm baths, though but infrequently; moist warm packs constantly, and several times daily friction with a solution of vinegar, salt and alcohol, and dry hot-air baths. In all cases the bowels were freely evacuated as early as possible by means of salines (equal parts of sodium sulphate and magnesium sulphate). Besides, careful attention was given to the functions of the kidneys. These were stimulated by the administration of milk and mineral waters, and the application of heat in the lumbar region over the kidney by means of a large rectangular hot-water bag. Only in one case was bleeding practised.

For Coryza in Children.—

R.—Atropinæ sulph.	.	.	.	gr. $\frac{1}{100}$
Morphinæ sulph.	.	.	.	gr. $\frac{1}{15}$
Quininæ sulph.	.	.	.	gr. $\frac{1}{15}$
Strychninæ sulph.	.	.	.	gr. $\frac{1}{100}$
Acidi arseniosi	gr. $\frac{1}{100}$ —M.

Ft. pil. To be taken every hour until dryness of the throat is felt, and then followed by minute doses of apomorphin every two hours.

—TAYLOR, *Phila. Polyclinic*, vol. iv, No. 7.

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SATURDAY, MARCH 9, 1895.

THE APOTHEOSIS OF HYSTERIA AND WHIMSICALITY.

ONE of the functions of a medical journal is to notify its readers of the appearance of new and important medical works, and so deeply are we impressed with the transcendent importance of one such book recently issued, that we believe we are doing a great service to medicine by a somewhat extended and free advertisement of it. It is by W. A. DEWEY, M.D., a late professor of *materia medica*, an editor and associate editor of numerous medical journals, an author and associate author of several medical works, a member of many medical societies. The last title the learned author gives himself on the title-page of his book is simply this: "*Homeopathic, etc., etc.,*" which reminds one of a drug catalogued by the New York homeopathic druggist, SWAN, as "Omnia." The book to which we call especial attention is entitled: *Essentials of Homeopathic Therapeutics, being a Quiz Compend upon the Application of Homeopathic Remedies to Diseased States*, and is published by Boericke & Tafel, Philadelphia, 1895.

"One of the grand cardinal features of homoeopathy," says the author in his preface, "and one little understood by the allopathic school, is the

fact that any drug in the entire homeopathic *materia medica* may be a remedy in any diseased state. It is, therefore, evident that the preparation of this work entailed no little difficulty, etc." In view of the infinite multiplication of "remedies," and of the numerous different "potentizations" of each, together with the literally bewildering multiplication of "symptoms" or "provings," this modest qualifying reservation is very appropriate, as otherwise all the books that have ever been printed could not contain the possible "Application of Homeopathic Remedies to Diseased States."

Before passing to the subject-matter of the volume we cannot forbear a word of criticism as to the strange fatality that makes it impossible for our homeopathic friends to write sentences according to the fundamental rules of English grammar. In reading this remarkable work, for example, we seem to hear the echoes of some half-forgotten *patois* in which philologic crudities, barbarisms, and grammatic impossibilities vie in vain with pseudo-scientific whimsicalities and medievalisms. The very contractions used of the names of drugs make one smile, as, e.g., croton tig., carbo veg., Lyc., carbo an., Kali bich., etc. How can one who knows that the word *blepharospasm* itself means twitching of the lids speak of "a blepharospasmus twitching of the eyelids?" To one not conversant with occultism, the works of Mme. BLAVATSKY, or the strange use of language by the homeopaths, a large number of the sentences are absolutely devoid of meaning. One wonders how symptoms can be called "female symptoms," or "male symptoms," what sentences without verbs can signify, what the personification of drugs betokens, etc. Of these grammatical peculiarities, of which certainly every second sentence is an illustration, we quote a few examples that have attracted the attention:

The sensations are throbbing, which is intense and sudden, and the pains are apt to cease as suddenly as they appeared.

Stramonium has visions of animals coming towards him from every corner.

It is a hoarse, croupy cough, but withal a loose edge.

The patient clutches the air; sometimes a stupor, which, if aroused out of, they strike people.

The child appears to have but one bowel extending from mouth to anus.

The diarrhea of Thuja is a chronic diarrhea traceable to vaccination forcibly expelled like water from a bung-hole.

What drug has nausea at the thought of food? even mention food and he vomits.

Gulping up of burning water.

The patient is excitable, restless and fidgety. They are awkward and clumsy.

Where does Kali bich. come in?

What drug has a great deal of depression about his chest, is tearful and discouraged, and fears that he will go into decline?

Patient thinks she will go crazy, is suspicious, has visions of rats, etc.; is conscious, but can't help it.

Stannum has characteristically falling of the womb during hard stools.

In glancing through this volume one is struck by the almost maniacal revelling in the nasty. Every possible discharge or excretory product of the body (our author would call it "a secretion from the body") is described, with a vividness of language, and with a fond enumeration of the morbid varieties and of their unexampled filthiness; the catalogues of Rabelais pale before the telling word-pictures of our author. This is undoubtedly due to the habit of treating symptoms rather than to a distinctly Rabelaisian type of mind however. This fact may also explain why *spermatorrhea* has the consideration of nearly three pages, whilst *peritonitis* has but half a page; why diseases of women require nine pages, whilst tuberculosis and "phthisis" combined require but three.

But this enumeration of symptoms—what awful absence of the sense of humor does it show, the perfect solemnity with which this apotheosis of hysteria is set down! A person, we suppose, has taken an infinitesimal amount of "carbo veg." and whatever morbid whims pass through his fancy for days are supposed to be "provings" of the drug, although any amount of carbo veg. in the shape of toasted bread may be eaten at other times.

Thus "phosphorus has evening hoarseness, while *Causticum* has morning hoarseness," "*lilium* is worse in the afternoon, *sepia* in the forenoon." One drug produces a sensation in the right arm, another in the left arm. One produces headache over only the left eye, or pain in the left ovary, headache upon one side of the head ("the pains following the course of the sun"), etc.

The explanation of a number of national traits is suggested by the assurance that among the mental symptoms of *gelsemium* is mentioned, "does not seem to care whether school keeps or not;" among those of *Platina*, "the patient is proud and haughty; looks down upon everybody with disdain; everybody seems beneath her;" among those of *Baptisia*, "He thinks he is scattered about, and he must move to get his pieces together again;" in children *chamomilla* produces the very human trait: "want

to be carried about, and want different things, and when they get them throw them away dissatisfied." Our neighbors, the Britishers, have often wondered why we Americans "like to sit with the feet on the table." They may now understand that it is due to "the effect of carbo veg. on the liver." Profanity, it would logically seem, might be lessened by restricting the sale of nitric acid.

In private practice we have often been told by patients that they had been given medicines for cataract for years by homeopathic practisers, and lo! here, Anno Domini 1895, is phosphorus commended therefor!

It is little wonder that the animosity against the "allopath" is so great that a drug having a general exercising or purifying effect is recommended as "the first remedy to use if the case comes from allopathic hands."

Quotation is better and more just to the talented author than any setting forth of his teachings in our own poor words. We therefore give free permission to scissors, to wit :

What drug has amenorrhea from getting feet wet?
What drugs have backache worse while sitting?

Arsenicum lacks the tingling of *secale*, and wants to be warmly wrapped up. *Secale* wants to be cool, and lacks the anxious tossing about and restlessness of *arsenicum*.

Mention three drugs having colic from a fit of anger.
All muriates have crumbly stools.

What drug has convulsions in children from rich food?
What drug has a cough that is worse when strangers are present?

In the diarrhea of aloes the patient loses confidence in his sphincter.

Arsenic wants little and often, *apis* thirstless. The bloating in *apocynum* is on the side on which he lies. *Arsenic* in the extremities. *Apis* under the eyes.

What drug has pain in the right eye as if it were pushed out of the head, worse near a warm stove?

What are the symptoms to China in dyspepsia?

What drug especially desires oysters?

What drugs have the symptom that the patient has to loosen the clothing after eating?

When a hemorrhage is due to a strain or misstep cinnamonum is to be given.

Belladonna is relieved by being propped up in bed, while *sanguinaria* has relief from lying down. *Belladonna* was not so marked.

What drugs have headaches relieved by copious urination?

What peculiar symptom has Oleander in the head? Headache relieved by looking sideways.

Arsenic has hypertrophy of the heart, resulting from climbing high places.

"Castoreum the secretion from the beaver" (sic) is recommended for "women who are pretty near the hysterics."

Where do the pains of Croton tigium go upon nursing ?
To the back.

What drug has the symptom that the patient predicts
the hour of death ?

What drugs have hasty speech and hasty drinking ?

What symptoms has anacardium ? It produces a
weak memory ; he imagines he hears voices, and another
condition is a propensity to swear ; it is mental condition,
and it does not exist as a condition of low morals.

What other drug produces a disposition to swear ?
Nitric acid ?

The *staphisagria* child is impetuous and irritable, re-
minding one of *chamomilla*.

What are the mental symptoms of sepia ? The patient
is low-spirited, cries readily ; weak memory ; there is
sadness and irritability ; it will not do to find fault with
her ; there is also perfect indifference, especially to
household affairs and to her own family ; the patient is
easily offended ; she dreads to be alone, wants company,
but has an aversion to her own friends.

How is *Sepia* distinguished from *Pulsatilla* ? Both
have weeping, anxiety, peevishness, and are ill-humored ;
but *Pulsatilla*, only, has the mild, clinging disposition
calling for consolation ; she makes her grief known and
asks sympathy. The *Sepia* patient is worse from gentle
exercise, but is relieved by violent exercise.

What drugs have the symptom that the patient has to
think how words are spelled ? (*Spelling-reformers will
take notice !*)

What are the mental symptoms of sulphur ? Patient
feels she will not be saved ; there is anxiety about her
own soul, but perfectly indifferent about the souls of
others.

With Hepar sulph. the patient is especially sad in the
evening, and does not wish to see members of his own
family. (*And thus at last is an explanation and a cure
assured for a sad social custom !*)

With antimonium crudum the crossness of children is
increased by washing them with water.

With gelsemium the patient does not seem to care
whether school keeps or not.

What is the Graphites temperament in general ? Sad,
fat, fair and constipated.

What drug has the symptom that the soul feels as
though it were freed from the body ?

What drug has special action on the right wrist ?

The *Natrum carb.* patient gets very nervous during
thunder storms and hides in the cellar. This nervous-
ness is said to be due to the electrical condition of the
atmosphere acting on such patients.

Pulsatilla is mild, tearful and whimsical. *Sepia* is
depressed, easily excited and irritable. *Pulsatilla*—
blondes. *Sepia*—brunettes.

What drug cures nymphomania from worms crawling
into vagina and there causing irritation.

What drugs have especially sensitiveness to coitus ?

What are the menses of calcarea carb ?

What drug has menses flowing only in daytime when
about on feet ?

What drug has early and scanty menses in tall slender
females ?

Medicine is a serious study and the medical life
is proverbially a solemn one. Perhaps we have

quoted too extensively from our valued author, but
his teachings we trust may be found at least tem-
porarily a good "regular" dose antidote of the
gloominess of our calling. The richest and most
perfect humor in the world is the unconscious
variety, that wherein the most profoundly earnest
joker dreams least of all things that he is pro-
ducing a work that will inspire most uproarious
laughter in thousands of readers.

But after the laugh the return to work ! After
the fun the payment of the bills ! Thereupon
come the indignation and the disgust—the thought
that it is for the encouragement of this sort of
nauseating drivel that our aristocratic society gives
"charity balls ;" for this that our legislators vote
hundreds of thousands of dollars of the people's
money ; this gibbering ghost of medieval medicine
it is that an intelligent and discriminating people
call the "new school ! "

STATE APPROPRIATIONS FOR PRIVATE HOSPITALS.

BEFORE the Pennsylvania State Legislature the
various charitable institutions have laid their appli-
cations for appropriations for the years 1895 and
1896. The amounts asked for by hospitals of the
third class, that is, hospitals owned and controlled
by private corporations, are

For the year 1895	\$1,446,211 93
" " " 1896	1,019,500 00

About one-half of this is for new buildings or for
removing debts of mortgage, and one-half for
maintenance.

When an individual endows a bed in a hospital
he has a right to send anyone there, at any time, to
occupy such a bed. When the State gives a grant
of \$50,000 it virtually endows ten beds, yet does
not possess any right to such beds. The only place
a poor incurable tuberculous or other invalid need-
ing the attention a hospital can give has a right
to go is the Philadelphia Hospital, and here, alas,
there is but little room for him.

The private hospitals often obtain their appropri-
ations only through strong lobbying, and if a charity
has a "pull" it can get almost anything it wants.

A few individuals organize a hospital, largely
and principally for their own benefit, and then
obtain appropriations from the Legislature, by
which they can erect costly buildings and bring
themselves into prominence.

If institutions are to receive State aid, they should

be under State control, and where it is found that over-lapping exists, that one institution can do the work of two, the other should be dropped from the State list.

The following Philadelphia hospitals are represented in the applications:

Name of hospital.	Amount asked for 1895.	Amount asked for 1896.	Amount received in past six years.
Hahnemann	\$67,000	\$50,000	\$73,546
University	50,000	50,000	135,000, 4 yrs.
" Maternity	5,000	5,000	
" Veterinary	5,000	5,000	30,000, 4 yrs.
St. Timothy's	12,500	12,500	7,000, 2 yrs.
Kensington, for Women .	13,500	5,000	5,000, 2 yrs.
Polyclinic	25,000	25,000	87,000
Jefferson	50,000	50,000	130,000
Woman's	25,000	25,000	25,000
Howard	2,500	2,500	
Medico-Chirurgical . .	82,500	82,500	170,000
Rush Hospital	75,000	75,000	
West Phila., for Women .	12,500	12,500	
Women's Homeopathic .	17,400	17,400	67,000
Children's "	17,000	17,000	8,000, 2 yrs.
St. Christopher's	5,000	5,000	
Philad'l'a Lying-in Charity .	7,500	7,500	15,000
Southeastern Dispensary .	2,500	2,500	
Orthopedic	23,500	23,500	30,000
Maternity	8,000	5,000	15,000
Gynecean	20,000	15,000	85,000
Wills Eye	10,000	10,000	40,000, 4 yrs.
Samaritan	30,000	30,000	
German	10,000	10,000	40,000, 4 yrs.
Hospital for Incurables .	20,000	20,000	

It will be noticed that all of the foregoing institutions, with the exception of Wills Eye Hospital, which is in trust of the city, are strictly private concerns. They are not obliged to render account to any public official. The funds received may or may not be applied to the purposes for which they are asked.

The Governor has but recently stated that economy is necessary in the affairs of the State. Let the Appropriation Committee turn to the private hospitals first.

We want a State Hospital for Epileptics and two or three for tuberculosis, but let these be managed by the State as the hospitals for the insane are.

We hope that the medical profession of Pennsylvania will enter a protest against indiscriminate grants to private charities, and ask that State moneys be applied to institutions under State control.

EDITORIAL COMMENTS.

As to Physio medicalism.—We have received two letters concerning "errors" and "falsehoods" contained in the little historic article of Dr. Nichols on Physio-medicalism in THE MEDICAL NEWS of February 9, 1895. Although we are not responsible for the opinions ex-

pressed in signed contributions to our columns, we shall make brief answer to these criticisms editorially, because of our lack of space to accommodate both our critics and our contributor with replies and again replies. As to matters of opinion and of medical philosophy, they are beyond our present province or interest; as to matters of accuracy in the statements of fact, they may be summarized as follows:

1. That Thomson's views were accepted by good and intelligent men of "cultured Boston" and New England, and, therefore, the views were true, and the man was "a man of talents and skill." The acceptance of an opinion by all the John Quincys, Batemans, etc., of New England, makes the opinion neither true nor false. If our critic will go to Boston to-day, he will find Harvard professors and the "bluest blood" of that quack-ridden city consulting clairvoyants, faith-curists, layers-on of hands, mesmerists, and spiritualistic mediums. Thus, as the critic would agree, instead of the aristocratic profession of faith proving the truth of the faith, it may only prove the intellectual degeneracy and *bêtise* of the aristocrat.

2. One of Dr. Nichols' critics (Dr. William H. Cook, of Chicago) takes exception to the statement that lobelia, capsicum, and the vapor-bath are the chief remedies of physio-medicalism. The information was derived from the writings of Alva Curtis and of Dr. Cook himself. (*Review of Allopathy and Defense of Physio-medicalism.*)

3. The critics contend that lobelia is not a poison, etc. The statement that lobelia is a poison is, we believe, the view generally held by such authorities as Bartholow, H. C. Wood, etc., Ringer to the contrary notwithstanding. Numerous references to fatal cases of poisoning may be found in the *Catalogue of the Army and Medical Library*. The statement that botanic practisers have been repeatedly tried and convicted for manslaughter caused by lobelia-poisoning was based on an article in the *Medical Times and Gazette*, of London, volume viii (1854), page 491, in which is given a list of thirteen cases of lobelia-poisoning in the three or four years preceding, in six of which a verdict of manslaughter was rendered. It was not said that there were ever any convictions of this character in America, nor do we think there have been.

Untruthful Clinical Histories.—If one asks a reputable English physician in reference to the statistics and character of a certain compatriot whose name and writings are well known, one is greatly puzzled at the fact that he gets no satisfactory answer. The one questioned probably stares silently into the air, with a tormenting expression of quizzical self-restraint, or he says something about his ignorance concerning the gentleman mentioned, or he cautiously hazards a word or two as regards the weather. After receiving such "answers" several times, if one "bulldozes" a friend and promises absolute secrecy, one may finally get a solution of the mystery in the brutal remark which bursts forth as if from a too-long-restrained reservoir: "Oh ! He's an infernal liar ! You can't believe a word he says."

Truth compels us to admit that the English by no means have a monopoly of the article in question. Undoubtedly, one must not believe all the vindictive sneers and scandal that is or that may be set going by jealous rivals or personal enemies. Undoubtedly, also, there are

entirely too many such malicious stories passed from none too clean mouths to avid ears. But again, undoubtedly, there is one, or, perhaps, there are several specimens of the genus liar in the medical profession. Beyond question, also, these specimens are infinitely better known than they themselves suspect. Very recently a physician read before a large society a paper, since much reproduced and quoted, in which he took decided grounds against the position previously assumed by one whose conservatism, honesty, and scientific quality of mind are beyond question. His opposition was bolstered up by reports of cases. As the reports were read a clinical assistant of the reader, sitting on a back seat with several friends, introduced parenthetic remarks, *sotto voce*, to the effect that one "cured" case had lately returned no better than before the cure, that another had not been buried from the hospital, that yet another had been sent home to die, etc.

Here is concealed a fallacy that more or less vitiates all medical statistics, and induces the undiscerning to repeat an operation or a method of treatment to the cost of the patient and to the shame of the physician. He who in the least falsifies his clinical reports is a criminal against his profession and against humanity.

Phonography in Medicine.—There can be no question that a medical man fortified with an ability to write short-hand possesses a decided advantage over one who lacks this accomplishment. Too much importance cannot be attached to the making of full and detailed clinical records, but the difficulties are numerous and great, particularly in private practice, where the work cannot always be detailed to clinical clerks or assistants. These difficulties can in large measure be overcome if stenographic notes are made at the time of investigation. Further, a recent graduate will find useful application of his phonographic ability in the reporting of lectures or similar work, for which he is likely to have time during at least the early part of his professional career. Good medical stenographers do not exist in excessive numbers, and the remuneration may help tide over a critical period.

The distinguished neurologist, Dr. Gowers, himself an adept and enthusiastic stenographer, has long insisted on the wisdom of medical men educating themselves in phonography. With the aid of others he has organized a Society of Medical Stenographers, which publishes monthly (except during April, August, and September) *The Phonographic Record of Clinical Teaching and Medical Science*, containing stenographic reports of lectures by medical men, and other articles and matters of interest. It is proposed also to issue from time to time supplements containing matters of combined medical and phonographic interest. A list of more than 1800 vocalized outlines of medical terms is in course of preparation for distribution among the members of the society. The *Record* is edited by Drs. Gowers and Taylor. The annual subscription is, for medical men, five shillings; for medical students, three shillings. Dr. Neil, Warneford Asylum, Oxford, Eng., is the honorary secretary.

The Reprint Advertisement.—In partisan politics one of the most disheartening things is not that men can stoop to such scoundrelism as they do, but that the humbuggery is so evident. It depresses one to find, first, that a man

can try to play so poor a trick, and play it so poorly; and, second, that there is any considerable number of one's fellow-citizens so stupid as to be fooled by such evident hypocrisy and nonsense. In medicine we have the same causes for wonder. As one takes note, for example, of the tricks of the advertising specialist, he is shocked to think that there are so many *confrères* who can be hoodwinked by such specious buffoonery. There must be many who are taken in, or it would not pay to do it so much.

We have before us as we write a pamphlet purporting to be the reprint of an article published first in a medical journal. The first page is filled with a portrait of the author of the pamphlet, under which appears the name with many and long degrees and titles of the professor, his addresses, office hours, etc. The atrocities of the illustrations, artistically and anatomically, make us wonder if it is not a mistake that even a single copy of the reprint should have found its way into professional hands. Was it not meant for distribution among possible patients rather than among physicians?

Even the Carpet-cleaners are After Us!—Physicians of a large city are receiving the following letter:

DEAR SIR: We beg to call your attention to the enclosed card. Knowing that you are called upon when sickness enters a home, we would consider it a great favor, if, whenever possible, you would mention our name and address to the person in charge of the house, stating that after sickness or death feather beds, bolsters, pillows, and hair mattresses are often soiled, and therefore prejudicial to good health, and the same should be renovated and disinfected. We do this thoroughly by our steam process, removing all impurities, etc., and making the articles equal to new.

On all orders we receive through you, we will gladly allow you 25 per cent. commission, which shall be remitted to you promptly, or accounted for on any work of your own.

Trusting you will consider this favorably we are,

Yours respectfully,

Dr. William T. G. Morton.—Among the fifty-three names which are to be inscribed as a roll of honor in the dome of the new chamber of the House of Representatives, in the State House, at Boston, and each of which is intended either to mark an epoch or to designate a man who has influenced the course of events, we note that three were borne by members of our profession. Only one of these three, however, was chosen on account of eminent services to medicine. The name so dignified is that of Dr. William T. G. Morton, who was the prime mover of the experiments which led to the establishment of anesthesia by sulphuric ether as a matter of practice. Of the priceless value of this boon to the human race, it would be superfluous at this day to speak. That the name of the man through whom it came should be held in lasting honor, and given a high place in the list of benefactors to mankind, is but just and right.

The Montefiore Country Home for Consumptives is the name of a new non-sectarian institution to be established in New York for the gratuitous treatment of the tuberculous poor. Mr. J. H. Schiff and Mr. L. G. Bloomingdale have each contributed \$25,000 for the purpose.

REVIEWS.

A TEXT-BOOK OF THE PHYSIOLOGICAL CHEMISTRY OF THE ANIMAL BODY, INCLUDING AN ACCOUNT OF THE CHEMICAL CHANGES OCCURRING IN DISEASE. By ARTHUR GAMGEE, M.D., F.R.S.
VOL. II. THE PHYSIOLOGICAL CHEMISTRY OF DIGESTION. Pp. 528. London: Macmillan & Co., 1894.

THIS volume forms, like its predecessor, which appeared in 1880, an independent and complete treatise. The first volume, now undergoing revision, was devoted to the physiologic chemistry of the elementary tissues of the animal body. The present, of more practical interest to the laboratory-worker and to the clinician, deals with the physiologic chemistry of digestion, and forms a work based, as the author states, on an original study of the whole literature of the subject, and is intended as "an accurate guide to the advanced student and the original worker, both in the study and in the laboratory."

Dr. Gamgee writes in an attractive style, approaching his subject from the standpoint both of a physiologist and a chemist. He discusses at length not only the physiology of the digestive processes occurring in the body, but also the pathology of jaundice, the pharmacology of the icterogenic poisons and of cholagogues, and the structure and formation of gall-stones. The important intestinal processes resulting from the activities of microorganisms are not omitted, and a description of the formed enzymes, some seven individual species, normally present in the intestines, is included. Stress is especially laid on the little-known fact that, as a result of the same bacterial action, so great is the quantity of organic acids, chiefly lactic, formed in the bowel, the intestinal secretions, from pylorus to cecum, are practically never alkaline, excepting those of the duodenum at the time the pancreatic juice is being most actively secreted. He points out that it is through the agency of these same microorganisms that the bile indirectly owes its antiseptic virtues; the lactic and other acids so formed from the carbo-hydrates, after neutralization of sodium carbonate secreted by the mucous membrane during digestion, liberate from inactive combination a certain amount of bile-acids, so powerful in inhibiting putrefactive intestinal processes. Concerning gall-stone formation, he points out, according to the view of Naunyn, that these are probably the result of an infectious process, and occur through the migration of bacteria from the duodenum, exerting a pathogenic action on the mucous membrane of the bile-passages, this same migration being facilitated by sluggishness of biliary flow. It is shown that the increase of the frequency of gall-stones in the aged is thus indirectly the result of diminution of respiratory activity leading to stagnation of bile in the ducts. He also cites the other important factor, that of atrophy of the unstriated muscular fibers existing in the walls of the bile-passages, this last condition especially leading to formation of concretions without symptoms of colic.

The interesting fact, yet not generally known, is also fully noted that so-called hematogenous or non-obstructive jaundice does not exist, it now being settled that jaundice is always due to obstruction to the normal efflux of already-formed bile. The biliary acids and col-

oring-matter are both formed in the liver, so that extirpation of that viscus in animals does not occasion jaundice, even under conditions that might be supposed otherwise to produce the falsely called hematogenous form. It is, moreover, proved that by ligation of the thoracic duct, as well as of the common bile-duct, no jaundice ever results, so that it is only through the lymphatics that the biliary elements can reach the blood.

Although the large part of the work devoted to a consideration of the physiology of gastric digestion leaves nothing to be desired, the author in his directions for practical laboratory-work in this line of importance to the clinician displays a lamentable ignorance of modern manipulative clinical and chemic methods, an ignorance so common with the English, who have so totally neglected the important field of applied gastric chemistry. Whatever may be said concerning the utility of a knowledge of the newer methods from a therapeutic standpoint, our debt to them as an aid in diagnosis is undoubtedly. Dr. Gamgee does not question either, and it is for this reason the more surprising that his book does not show evidence of his having done some practical work in this field so ripe for research. His description of methods for clinical laboratory-work in the body of the book are antiquated in the extreme, both in the mode of examination of the stomach-contents and that for obtaining the same. If the barbarous and antique aspirating method for the latter, illustrated on page 165, is popular in England, as one is led to suppose, there is slight wonder that a feeling there exists against the employment of the stomach-tube save as a *dernier ressort*. As curious a method is illustrated for lavage on page 166, and in his description of Ewald's trial-meal he speaks of a *well-buttered (!) roll*.

In a consideration of gastric digestion in special diseases Dr. Gamgee clings to the old English method of symptomatic nomenclature, and minutely describes a *flatulent*, an *acid*, and an *atonic dyspepsia*, as if they were special morbid entities, wholly separated from acute and chronic gastric catarrh, ulcer, atrophy, and carcinoma of the stomach, all separately noted. No mention is made of the neuroses of the stomach. These forms of dyspepsia, from the symptomatology cited, should clearly fall into some groups of these diseases. He is not up to date in these matters, as other unquoted passages plainly show. In the appendix Dr. Gamgee partly atones for the deficiency in one of these particulars. Here, in a few pages, the data for which he draws from the recent work of Martius and Lütke, he gives in epitome an account of more approved methods of procedure in the examination of the stomach-contents.

Apart from the weakness in these particulars, the work is a splendid achievement, and will long live, with its sister volume, as an enduring monument to the fame of the distinguished author.

DISEASES OF THE EAR. A Text-book for Practitioners and Students of Medicine. By EDWARD BRADFORD DENCH, Ph. B., M.D., Professor of Diseases of the Ear in the Bellevue Hospital Medical College, etc. Pp. 645. New York: D. Appleton & Co., 1894.

THIS is a very handsome book, but it is too big. There are some glaring defects in the anatomic illus-

trations, though most of them are excellent. Why are two ossicles represented as lying loose in the tympanic cavity, as in Figs. 5, 3? This is grossly misleading to the beginner. Plates I, II, III, and IV, of the vascular and nervous supply of the middle and internal ears, are especially good.

The pages on physical examination of the ear are, for the most part, good; but we are surprised to find the position of the light shifted from the surgeon's right to his left, as on page 87. His left arm would thus be likely to get between the light and the mirror. Catheterization of the Eustachian tube is marred by the introduction of the old, impracticable, and septic catheters of Noyes and Pomeroy, and also by the suggestion to cocainize the nose before using the catheter. This is wholly unnecessary if the operator understands how to catheterize the Eustachian tube. If he does, he will not hurt the patient. Force should never be exerted, either with or without anesthesia.

Local abstraction of blood and incisions do no good in furunculosis of the ear. As they provide new furrows for the growth of septic germs, they do positive harm. So in acute otitis media, local abstraction of blood never aborts the inflammation; if dry heat will not relieve the congestion and pain, paracentesis is the only means of relief to pain and escape of the exudation.

Under middle-ear operations the author avails himself largely of the experience of other American aurists, even using their terms, like "stapedectomy" (Blake and Jack), without mentioning their names. He is the youngest worker among many older ones, in this field, in this country; but from his text one might justly infer that he is the only one. Buck and J. O. Green, who have labored for twenty years in mastoid surgery, are not even mentioned in this connection. Surely this young author should not withhold what is due these observers.

A MANUAL OF DISEASES OF THE EAR FOR THE USE OF STUDENTS AND PRACTITIONERS OF MEDICINE. By ALBERT H. BUCK, M.D., Clinical Professor of Diseases of the Ear, College of Physicians and Surgeons; Columbia College, New York; Consulting Aural Surgeon, New York Eye and Ear Infirmary, and the Presbyterian Hospital. Second revised edition. One volume, post octavo, 467 pages, illustrated, with blank memoranda pages at the back. New York: William Wood & Co., 1895.

THIS book is commendably compact and of very reasonable price. It sets forth the general consensus of opinion as to the treatment of ear-diseases down to within about ten years, since which time our knowledge of bacteriology has gradually modified the views of many aurists concerning the treatment of ear-diseases, especially of acute otitis media. In this malady, if dry heat, or in some cases, if the mechanical pressure upon the membrana can be endured, warm instillations of carbolic-acid water (1.50 per cent. to 2 per cent.), cannot abort the process and ease the pain in five or six hours, spontaneous rupture must not be awaited, but paracentesis of the drum-membrane performed. Immediately upon the appearance of a discharge, either after paracentesis or a spontaneous rupture of the membrana tympani, the ear should be drained by placing in the

auditory canal a narrow strip of iodoform-gauze or carbolic-acid-gauze, the meatus gently stopped with a little iodoform-cotton, and the ear let alone for twelve hours, or even longer, if the discharge is not copious. It is a mistake to syringe the ear, to drop anything into it, or to inflate the tympanum as soon as an ear begins to run, for fear of secondary infection of the middle ear. Drainage of exudation by way of the auditory canal is rather to be favored, for thereby the pathogenic organisms are carried from the middle ear. If the original acute otitis media is properly treated, no mastoid complications can ensue. The mastoid cavity has the ability to empty itself siphonically through the auditory canal, as it does probably in every case of acute otitis media in which the escape of the exudation is not impeded and in which no secondary infection is artificially set up.

The chapter on "Analysis of Symptoms" is a new one and of value to the general practitioner. The author is at home in the chapter on mastoid disease and operations. He rejects all intra-tympanic operations in chronic catarrh of the middle ear, but regards them as indicated to some extent in chronic purulent otitis media. But the ideal book, of not more than 300 pages, for "students and practitioners of medicine," has yet to be written. There are few things these busy men can learn of otology, and still fewer they can do for diseased ears. They could be told, however, that little, and also what to avoid even attempting to do, in much fewer words than this book, most valuable to a specialist, contains.

TEXT-BOOK OF NERVOUS DISEASES, BEING A COMPENDIUM FOR THE USE OF STUDENTS AND PRACTITIONERS OF MEDICINE. By CHARLES L. DANA, M.D. Third edition. With 210 illustrations. New York: William Wood & Co., 1894.

A WORK that has gone through three editions has received the stamp of professional approval, and any criticism thereon must be in the way of suggestion for further improvement rather than a judgment adverse to the merit of the work. Dr. Dana's style of writing is clear, and if he is somewhat more dogmatic than the present certainties of science justify, it is a fault to be excused in a teacher, and, perhaps, rendered necessary by the great condensation to which he has submitted the complex and difficult subjects of which he treats.

We are pleased to note that the author gives his adherence to that theory of exophthalmic goiter which regards the disease as an ataxia, or, to use the author's own language, a neurasthenic condition of the vaso-motor centers and the visceral nerves. The attention which he devotes to hydrotherapy and his just estimate of the value of electricity are useful features of the book. The author speaks favorably, perhaps more so than the facts quite warrant, of the use of extracts of brain and nervous tissues in treatment. We must record our emphatic disapproval of the proposition to use tuberculin in the diagnosis of tuberculous meningitis. Some of the illustrations are useful; others are either so poorly executed or so overcrowded as to be rather more confusing than helpful. On the whole, however, the book is the best compendious work upon its subject in the English language of which we have knowledge, and we can once more commend it to our readers.

SYLLABUS OF LECTURES ON HUMAN EMBRYOLOGY: AN INTRODUCTION TO THE STUDY OF OBSTETRICS AND GYNECOLOGY. FOR MEDICAL STUDENTS AND PRACTITIONERS. WITH A GLOSSARY OF EMBRYOLOGICAL TERMS. By WALTER PORTER MANTON, M.D., Professor of Clinical Gynecology and Lecturer on Obstetrics in the Detroit College of Medicine; Fellow of the Royal Microscopical Society, of the British Zoological Society, of the American Microscopical Society, etc. Illustrated with seventy outline drawings and photo-engravings. 12mo, cloth, 126 pages, interleaved. Philadelphia: The F. A. Davis Co., 1895.

In the preparation of this syllabus Dr. Manton has drawn not only upon the last editions of all of the standard works upon comparative and human anatomy, embryology, physiology, and obstetrics, but he has also consulted the recent current medical literature upon the subject, including the *Journal of the Royal Microscopical Society*, the *Zeitschrift für Geburtshilfe und Gynäkologie*, and the *Archiv für Gynäkologie*. The diagrams and drawings are largely original and are taken in part from specimens in the author's private collection. The book is interleaved for additional note-taking, and is made to meet the student's needs. The material is concisely and accurately presented, and as a syllabus the book merits honorable mention, especially from an obstetric point of view.

CORRESPONDENCE.

AN UNUSUAL SKIN-DISEASE.

To the Editor of THE MEDICAL NEWS,

SIR: H. G. R., male, single, aged thirty years, was by occupation a contractor and builder. Eight years ago, after skating continuously for ten hours, dressed in tights, he became quite warm, and walked from the rink to his hotel, a distance of six squares, dressed in his thin, close-fitting attire. From this exposure he became very much chilled, and immediately afterward, while changing his clothing, he was seized with an intense itching or irritation of the skin. This irritation began on the legs and thighs, but gradually extended all over the body, except his feet and scalp, which have never itched. Since that time he has been variously and vigorously treated, often with no relief whatever; but during this time, since the disorder first made its appearance, he has been entirely relieved for a period of twelve months, though the trouble would eventually return, and with each recurrence the irritation would be as intense and general as in former attacks. Upon examination of the skin I find the condition one of desquamation; as he exhibits the affected parts, beneath, on the floor, it appears as though there had been a light coat of fine meal dusted. On close inspection of the skin around the roots of the hair is to be seen a small scarlet or delicate pinkish eruption about the hair-follicles; the intervening skin is cracked or fissured, and is soon cast off. The discolored points are about half as large as the head of an ordinary dressing-pin. The itching is irregular, more intense at times than others. Sometimes it is worse at night; at other times it annoys him more in the daytime, and is more intolerable during cool weather than warm, for he states that during the summer

or warm weather when at work and perspiring he is but little annoyed till he cools off, when it begins again. He states that following the periods that he was free from it, each return would follow some exposure to cold air. Accompanying this irritation are attacks of cold, chilly sensations, beginning at or near the coccyx and gradually increasing in extent and severity to one or both lower extremities. He says that when the itching is worse on the legs he can often get relief or render it unnoticeable by crossing his legs, with the worst one on top, and engage it in a swinging motion. His appetite is good, also his digestion. He sleeps well also. Occasionally, however, he is prevented from sleeping for an hour or two after retiring. He has no bad or vicious habits, never drank intoxicants of any kind; smokes and chews tobacco but little, and never had a venereal disorder.

What is the nature of this disorder? I should like to hear from experts on skin-disorders or upon nervous affections, according as the case may be classified.

Most respectfully, A. B. BAIRD.
OKLAHOMA CITY, O. T.

DEATH FROM "BABY DROPS."

To the Editor of THE MEDICAL NEWS,

SIR: I was recently called to see a four-months old infant to which a fatal dose of "baby drops" was given about two hours before. The following are the facts in the case:

The mother was in the habit of administering daily the required amount of "Lemberger's Magnesia Infant Drops," manufactured at Lebanon, Pa. On the previous day she had drained the bottle. Her druggist was out of Lemberger's, and he therefore influenced her to take "Mrs. Winslow's Soothing Syrup." Of this the label-dose was given without the desired effect following. A few hours later she concluded to rinse the sediment from the Lemberger bottle; and accordingly gave the entire quantity to the infant. In a very short time, indeed before it could finish nursing, it was sound asleep.

Its peculiar respiration and the strange appearance of the eyes soon caused alarm. When I first saw it the pupils were contracted to the size of a pin-point, and the respirations were stertorous, irregular, and greatly reduced in number. The child could be aroused with great difficulty, after which it relapsed almost immediately into a deep stupor. It could not swallow. It had been healthy from birth.

In view of the fact that fully two hours had elapsed since the toxic dose was given I decided to resort to atropin hypodermically, faradic electricity to the diaphragm, and cold water to the face. In this way life was sustained for sixteen hours. After twelve hours the symptoms of narcosis became associated with those of increasing depression. Paralysis of the centers of respiration was almost complete. In the height of the effect the respirations were reduced to two or three per minute, the longest intervals being thirty and even forty seconds. I used tentatively small quantities of alcohol injected, but all to be finally disappointed. The infant died a victim to the inhuman practice of drugging well babies to sleep, a custom as vicious as it is common.

J. R. JOHNS.
DENVER, PA.

A METHOD OF TREATING ALCOHOLISM.*To the Editor of THE MEDICAL NEWS,*

SIR: In reply to the request contained in a recent number of *THE MEDICAL NEWS* for formulæ antidotal to the craving for alcoholic liquors, I would say that the great physiologic antagonism between atropin and alcohol does not seem as generally understood as it might be. If very small doses (less than $\frac{1}{100}$ gr.) of atropin be administered hypodermically three or four times daily to a victim of the liquor-habit, it will produce a great distaste for alcoholic liquors in from one to five days. Whiskey will become repellent both as regards sight and odor, and will have a most intolerable taste—as one man expressed it, like turpentine or benzine. If, under these circumstances, drinking is still attempted, it produces nausea and vomiting, without the addition of apomorphin or any substance whatever to the liquor. The drinker will almost invariably be turned completely against liquors in less than five days.

If this plan of treatment is pursued for its strong psychic effect, and if at the same time gentian, hydrastis, cinchona, strychnin, or other stomachic and general tonic is administered, with what other incidental remedies may be needed, it will constitute a very successful treatment of the liquor-habit, and when systematically carried out for three or four weeks will be very lasting in its effects. This curious antagonism between atropin and alcoholic liquors is the basis of some of the notorious "gold-cures" of the present day, and is a fact that should be used to better advantage by the regular profession in its treatment of the drink-craze. It should contraindicate or lead to caution in the administration of alcoholic stimulants to any patient already under the influence of atropin, hyoscyamin, or other mydriatic drug. In such cases it is likely to cause a foul, coated tongue, nausea, vomiting, insomnia, delirium, and possibly insanity.

C. C. CARTER.

243 EAST LONG STREET, COLUMBUS, O.

ON THE EARLY RECOGNITION OF CARCINOMA OF THE STOMACH.*To the Editor of THE MEDICAL NEWS,*

SIR: May I ask that you will permit me to add a brief postscript to my paper of February 16th, "On the Early Recognition of Carcinoma of the Stomach," that I may record the result of the last examination of the stomach-contents in the case mentioned on page 171, in which, although continuous improvement under treatment had occurred, no return of free HCl in the stomach-contents was evident at the time the paper was written (January 16th). A recent examination, made one month later, under the same conditions (the gastric contents removed one-and-a-half hours after Boas' gruel breakfast) showed a decided change for the better, well indicating the steady improvement that is occurring. Amount withdrawn 60 c.c.; well-solved, bile-stained. Congo paper blued and sharp Günzburg's reaction (demonstrating now, for the first time, the presence of free HCl). Total acidity : 40; no lactic acid; free and bound HCl:

0.06 per cent. Examination for pepsin not made, that for lab-ferment showed decided presence.

As concerns the diagnostic value of the presence of lactic acid, perhaps I did not lay sufficient stress in my paper on the fact that in the rare cases of carcinoma in which free HCl persists, despite the neoplasm, it is not to be expected that lactic acid will be found, save, perhaps in traces, the latter depending upon the percentage of free HCl present. As regards the negative value of the test, as recorded in the case related, it can, of course, only be regarded of utility in those in which, with symptoms simulating malignant disease, there also exist delayed propulsion and persistent absence of free HCl.

Very truly yours,

D. D. STEWART.

2620 N. FIFTH ST., PHILADELPHIA.

NEWS ITEMS.

A Private Hospital for Contagious Diseases in New York.—A wealthy lady has offered the Board of Health of New York \$25,000 to aid in the establishment of a private hospital for the treatment of contagious diseases, on condition that the money shall be used for no other purpose, that no part of it shall be applied to the improvement of any existing institution, and that the management shall be in the hands of the Board of Health and of a board of trustees appointed by the subscribers to the fund raised for the erection of the hospital.

Extra-mural Instruction in Medicine at Harvard.—The Faculty of the Medical Department of Harvard University has authorized approved physicians having the necessary facilities and desiring to teach its medical students to announce their courses in the Medical School.

The Sale of Patent Medicines in New York.—A bill has been introduced into the New York State Legislature giving the Board of Health the power to regulate the sale of patent medicines.

Dr. A. L. Benedict, of Buffalo, has been awarded the Merritt H. Cash prize of \$100, by the Medical Society of New York, for an essay entitled "Auscultatory Percussion and Allied Methods of Physical Diagnosis."

Dr. John Whitaker Hulke, President of the Royal College of Surgeons of England and Senior Surgeon to Middlesex Hospital, died on February 19th, at the age of sixty-five years.

Four Years' Course at the Yale Medical School.—The Faculty of the Medical Department of Yale University has decided to extend the course of study from three to four years.

Dujardin-Beaumetz, the distinguished French therapist and clinician, died on February 15th, at Nice, at the age of sixty-one years.

Dr. Roswell Park, of Buffalo, was recently elected President of the Medical Society of the State of New York.

Meetings of State and National Medical Societies:

	Meets.	Next meeting.	Meets.	Next meeting.
American Academy of Medicine.	May 4-6, 1895	Baltimore.	Medical Society of Virginia.	October
American Association of Genito-urinary Surgeons.	May 28-31, 1895	Niagara Falls, N. Y.	Medical Society of West Virginia.	July, 1895
American Dermatological Association.	Sept. 17, 1895	Montreal, Can.	Michigan State Medical Society.	June 4, 1895
American Electro-Therapeutic Association.	Sept. 3, 1895	Toronto, Can.	Mississippi State Medical Association.	April 10, 1895
American Gynecological Society.	May 28, 1895	Washington, D. C.	Mississippi Valley Medical Association.	September
American Laryngological Association.	May, 1895	Rochester, N. Y.	Missouri State Medical Association.	May 21, 1895
American Medical Association.	May 7, 1895	Baltimore.	Nebraska State Medical Society.	May, 1895
American Neurological Association.	June 5-7, 1895	Boston, Mass.	New Hampshire Medical Society.	May 30, 31, 1895
American Ophthalmological Society.	July 24, 1895	New London, Conn.	New Mexico Medical Society.	July 10, 1895
American Orthopedic Association.	Sept. 19-21, 1895	Chicago, Ill.	New York State Medical Association.	October 15-17
American Pediatric Society.	May 28, 1895	Hot Springs, Va.	Ohio State Medical Society.	May 15-17, 1895
Arkansas Medical Society.	May 1, 1895	Little Rock, Ark.	Ontario Medical Association.	June 5-6, 1895
Army and Navy Medical Association.	May, 1895	Decatur, Ill.	Oregon State Medical Society.	June, 1895
Association of American Physicians.	May 28-31, 1895	Washington, D. C.	Rhode Island Medical Society.	June 6, 1895
Association of Military Surgeons of the United States.	May 21-23, 1895	Buffalo, N. Y.	South Carolina Medical Association.	April 24, 1895
British Medical Association.	July 30-Aug. 2, 1895	London, England.	Texas State Medical Society.	April 23, 1895
Canadian Medical Association.	Aug. 28-30, 1895	Kingston, Ont.	Tri-State Medical Society.	April 2-4, 1895
Colorado State Medical Society.	June 18-20, 1895	Denver, Col.	Vermont State Medical Society.	October 10, 11
Connecticut Medical Society.	May 1, 1895	New Haven, Conn.	Washington State Medical Society.	May, 1895
Florida State Medical Society.	April 16, 1895	Gainesville, Fla.	Wisconsin State Medical Society.	June 5-7, 1895
Idaho State Medical Society.	Sept. 9-11, 1895	Boise City, Id.		
Illinois State Medical Society.	May 14-16, 1895	Springfield, Ill.		
International Congress of Hydrobalneotherapy.	1895	Ostend.		
International Medical Congress.	August, 1896	Moscow, Russia.		
Iowa State Medical Society.	April 17, 1895	Creston, Ia.		
Kansas State Medical Society.	May, 1895	Topeka, Kans.		
Kentucky State Medical Society.	June 12-14, 1895	Harrodsburg, Ky.		
Louisiana State Medical Society.	May 7, 1895	New Orleans, La.		
Maine Medical Association.	June 5, 1895	Portland, Me.		
Massachusetts Medical Society.	June 11, 12, 1895	Boston, Mass.		
Medical and Chirurgical Faculty of Maryland.	April 23, 1895	Baltimore, Md.		
Medical Association of the State of Alabama.	April 16-19, 1895	Mobile, Ala.		
Medical Association, District of Columbia.	April 2, 1895	Washington, D. C.		
Medical Association of Georgia.	April 18-20, 1895	Savannah, Ga.		
Medical Association of Montana.	April, 1895	Anaconda, Mont.		
Medical Society of the State of California.	April 16, 1895	San Francisco, Cal.		
Medical Society of Delaware.	June 11, 1895	Wilmington, Del.		
Medical Society of the Missouri Valley.	March 21, 1895	Sioux City, Ia.		
Medical Society of the State of New Jersey.	June 25, 26, 1895	Cape May, N. J.		
Medical Society of the State of North Carolina.	May 14-16, 1895	Goldsboro', N. C.		
Medical Society of the State of Pennsylvania.	May 21, 1895	Chambersburg, Pa.		
Medical Society of the State of Tennessee.	April 9, 1895	Nashville, Tenn.		

BOOKS AND PAMPHLETS RECEIVED.

Cauterization of the Nares, and Accidents that May Follow. By E. Fletcher Ingals, M.D. Pamphlet. Chicago, 1894.

A Contribution to the History of Medicine in Southern California. By Cephas L. Bard, M.D. Pamphlet. Ventura, Cal., 1894.

Report of the Ninth Annual Meeting of the Association of Executive Health Officers of Ontario, held at Chatham, Ontario, August, 1894. Toronto : Warwick Bros. & Rutter, 1894.

Military Medicine, Surgery, and Hygiene. Notes on the Introduction of the Tent Field Hospital in War. By Col. B. J. D. Irwin, M.D., Assistant Surgeon-General U. S. Army. Reprinted from the Proceedings of the Association of Military Surgeons of the United States.

A Series of Interesting Cases in the Service of Dr. Horace Tracy Hanks at the Woman's Hospital. By John H. Rishmiller, M.D. Reprinted from the American Gynecological and Obstetrical Journal, 1894.

Thirty-third Year of the Charity Hospital of the City of Philadelphia. Report of the Board of Trustees, 1893-94. Philadelphia : George B. Cole & Brother, 1894.

Rupture of the Drum-Head by Blows Upon the Ear. By Robert Barclay, A.M., M.D. Reprinted from the International Clinics, Vol. II. Fourth Series.

Zur Chininbehandlung des Keuch hustens. Von Dr. P. Baron. Sonderabdruck aus der Berliner klin. Wochenschr., 1893, No. 48.

Eleventh Annual Report of the Committee on Lunacy of the Board of Public Charities of the Commonwealth of Pennsylvania, September 30, 1893. Clarence M. Busch, State Printer of Pennsylvania, 1894.

Twenty-six Cases of Intubation of the Larynx. By Frank L. Day, M.D. Reprinted from the Boston Medical and Surgical Journal, 1894.

Treasury Department, Interstate Quarantine Regulations of the United States, September 27, 1894. Washington : Government Printing Office, 1894.